ALCOHOLISM AND DRUG DEPENDENCY

An Advanced Master Guide for Professionals

Issues and Treatment Procedures in After-Care

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This publication is

Sponsored by

Ministry of Welfare, Government of India
New Delhi 110 001

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Produced by

T.T. RANGANATHAN CLINICAL RESEARCH FOUNDATION
17, IV MAIN ROAD, INDIRA NAGAR, MADRAS 600 020

ACKNOWLEDGEMENTS

I would like to express my gratitude to the many people who have put in enormous time and effort in producing this Advanced Masterguide.

RUKMANI JAYARAMAN, our Honorary Consultant, wrote the core chapters of this manual including Relapse Prevention Planning and Counselling Techniques. Rukmani has been working on this manual for over two years. She has gathered extensive materials covering case studies, interviews, implementation tools, methodologies and research references and has condensed and presented them in a well structured format.

Counsellor **JAYASHREE VENKATARAMAN** wrote some of the technique-oriented chapters including Assertiveness Training. She took the trouble of meeting fellow professionals and specialists working in other institutions to seek their valuable suggestions on the text.

RAVI MENON went through the complete text several times over to improve the language and presentation.

Producing such a detailed manual involves tremendous volume of secretarial work. **GEETHA SUNDARAM** did the job single handed putting in late hours on the word processor. She took the initiative of making first level draft corrections and saved a lot of time for the authors.

Dr. S RAJARAM Lecturer at the National Institute of Mental Health and Neurological Sciences, Bangalore and **Dr. RAYMOL RACHEL CHERIAN,** Research Co-ordinator, Addiction Research Centre, Madras, were most kind and gracious in sparing much of their valuable time to go through the manuscript and provide suggestions for improvement.

SHANTHI RANGANATHAN

HONORARY SECRETARY

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INTRODUCTION

This book is for

* Counsellors
* Psychologists
* Social Workers
* Medical Professionals

Working in the field of Addiction Treatment

It is a guide to understanding

* Organisational and Administrative requirements of setting up an After-Care Centre.
* Special treatment procedures and methodologies to manage patients prone to frequent relapses.
* The need for qualitative life-style changes to effect long-term recovery.

We wrote it because

* Even experienced professionals, quite unnecessarily, tend to feel angry and guilty when a patient relapses despite their committed efforts towards his recovery and well being.
* Many professionals are still unaware of the positive role of After-Care services in helping the patient towards recovery.

This book will

* Provide the specialist with a deeper insight into the Relapse Dynamic.
* Empower the treatment professional with special tools, methodologies and step by step analysis of treatment procedures.
* Enable the Counsellor to derive greater job satisfaction in addition to professional development and growth.

A BRIEF NOTE TO THE COUNSELLOR

We have adopted some standardisations with regard to the terminology used in this manual. This is largely to ensure simplicity of presentation and clarity in understanding. The following notes will therefore be of use to you.

* This manual covers chemical dependency in general. However, expressions like addiction to alcohol, drug addiction, drug dependency have been used in specific contexts where appropriate. These may, therefore, be understood within the overall theme of chemical dependency.
* At the end of some key chapters, there is a place for **ADDITIONAL INFORMATION**. In this place, we have some of the following:

  i) Implementation Tools
  ii) Case Studies

* Case Studies are authentic. But the names and references have been altered to maintain confidentiality.
* The Counsellor is referred to as HE. You may also find expressions like therapist, professional, etc., in place of Counsellor.
* The word HE is used to denote the chemically dependent person. Again, this expression 'Chemical dependent' may find its near equivalent in alcoholic, addict, patient and client.
* The 'Family Member' is represented by the 'wife' and, therefore, referred to as SHE. Actually, it could also be a husband, father, mother or a guardian.
* The real value of this manual lies in the fact that a large part of it has been drawn out of our own experience both at the After-care Centre and our main Hospital in treating over 5,000 patients so far.
* Chemical dependency has now become an intense and pervasive social problem with a major social impact. Consequently, management of this problem, as also the methods of approach and treatment — all require continuous updating and tuning up.

  The After-care Centre of the T T Ranganathan Clinical Research Foundation would therefore welcome any information by way of feedback from professionals which may be relevant and useful in meeting this objective.

CONTENTS

1

WHAT IS AFTER-CARE?

Management of chemical dependency is a complex issue which has to be handled by professionals specialised in various disciplines. These specialists work together in the common task of treating and rehabilitating the dependent. Addiction treatment goes through three distinctly defined phases.

Detoxification

Detoxification, a process supervised by medical professionals, aims at withdrawing the person safely from physiological drug dependence.

Primary treatment

This includes a gamut of rehabilitation efforts through individual, group and family therapy, and can be a residential or an out-patient programme. Primary treatment aims at total abstinence from mood altering drugs. It emphasises the need for a qualitative change in the life-style of the patient.

After-care services

After-care includes any service offered to the patient after the goals of primary treatment have been largely met in order to help him to continue his sobriety. The package would be, follow-up counselling, self-help through Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.), referral to adjuncture services like vocational counselling, After-care centres or Half-way homes. After-care services reinforce the need to make positive life-style changes.

The need for after-care services

Recovery is not just the cessation of drug use; it also demands adjustment to a new way of life. The chemical dependent has to

rebuild each and every area of his life — family relationship, employment, finances, education etc. These activities can also impose new stresses and therefore require new coping skills. Recovering patients need hope and determination in the phase of change. To make a truly new way of life, chemical dependents need much more than grit — they must have guidance to acquire new skills and make new contacts for total recovery.

Following are a few problems they must learn to handle.

- There is the crucial issue of relapse. Relapse can be painful and can confuse the patient, his family and friends.
- Getting back to the same environment may pose a threat to sobriety.
- The negative emotions which the patient experiences lead to problems in recovery. Therefore, feelings of 'Guilt', 'Shame', 'Hurt', 'Anger' and 'Grief' have to be resolved.
- The recovering person may have to handle high risk situations and therefore has to learn to say 'NO' to drugs.
- He must also learn to respond safely to stress.
- Patients have to relearn new ways of life and start rebuilding their values.
- Recovering persons have to learn to lead a fulfilling life without resorting to chemicals.
- The patient should establish spiritual recovery by coming to believe in a Power greater than himself which can give him strength and confidence to manage the variety of challenges he is likely to face.
- Also the family may find it difficult for sometime to accept the person back into its system.

  Hence, the family has to be helped to recover*.

Goals of after-care services

To manage the challenges, the after-care services have certain specific goals. Researchers have suggested four reasonable goals for after-care services.

* Methods to handle the above challenges have been discussed in detail in the various chapters of this Manual.

1. After-care should increase family and other social support for successful living in the community without dependence on drugs and should seek to eliminate patterns of interaction with family and peers that contribute to relapses. In short, after-care should seek to develop or enhance social supports in the community.
2. After-care should seek to increase involvement in productive roles in the community, whether in work, school or at home.
3. After-care should facilitate the person's involvement in active recreational and leisure activities that do not involve the use of drugs.
4. After-care should assist the patient to recognise his negative emotions and deal with them appropriately.

Process in after-care services

The process by which change occurs in the recovering chemical dependent, begins with providing the patient with a drug free environment, which will help in his recovery. At the first instance, the patient seeks to replace his dependency on drugs with dependency on the After-care Centre. This can later on be shifted to make the patient depend on himself. Ultimately, the after-care programme aims at returning the patient to the community as a competent, functional, more or less independent person.

What is after-care centre?

The After-care Centre is one of the treatment modalities which was evolved in the late 1950's, largely as an outgrowth of the practice of Alcoholics Anonymous. After-care Çentres did not typically offer 'formal treatment' for addiction as was commonly provided in an in-patient or out-patient treatment facility. Few or no medical services were offered. It began as a supportive environment to the patients for a period ranging from several weeks to several months. It was viewed as a vehicle for providing shelter to the homeless recovering patient who had lost supportive family attachments. This group often could not adapt to or cope with the demands of independent living and social functioning following primary treatment. The After-care centre was a place for the person to initiate and stabilise his recovery process.

Definition of After-care Centre

The definition of an After-care Centre depends on the nature of services offered. A few definitions have been given below:

Source	Definition
Association of Half-way House Alcoholism Programmes of America 'AHHAP'. 1975.	Community-based, group oriented, residential facilities that provide food, shelter and service in a supportive non-drinking environment for the able-bodied and mentally competent recovering alcoholic.
National Institute on Alcohol Abuse and Alcoholism (NIAAA), 1977.	A transitional facility that bridges the gap between the Hospital and community living. Its purpose is to provide preventive and after-care services for alcoholics who do not need to be institutionalised, but would benefit from a supportive living arrangement.
National Drug and Alcoholism Treatment Utilisation Survey (NDATUS), 1982.	A community based, peer group oriented, residential facility that provides food, shelter and supportive services (including vocational, recreational, social services) in a supportive, non-drinking environment for ambulatory and mentally competent recovering alcoholics who may be re-entering the work force. It also provides or arranges for provision of appropriate treatment services.

Characteristics of an After-care Centre

The primary thrust of all After-care Centres revolves around the creation of an alcohol/drug free therapeutic environment that emphasises group living. More specifically, the centres share some common characteristics which have been outlined by Rubington E. (1979) and Noble E P (1977):

They are small in size, ranging in capacity from 10 to 20 beds.

They promote a strong A.A. orientation that attempts to provide the tools and support for recovery.

They provide insulation from alcohol/drugs.

They provide an informal, family-like environment and emphasise mutual help with a built-in group of acquaintances with similar problems.

Therapeutic benefits

Over a period of time, the effectiveness of the existing after-care services has been evaluated, and a number of research studies have consistently established the following positive outcomes.

★ After-care services help in prevention of relapses.

★ They equip the patient with alternative ways to deal with his emotions and manage the stresses of life.

★ They enable the patient to get back to productive employment.

★ They allow him to smoothly reintegrate into his family structure and consequently into the society at large.

Bibliography

1. **Addict After-care: Recovery Training and Self-help** by Fred Zackow, William E. McAuliffe and James M.N. Chien — National Institute on Drug Abuse, USA 1985.

2. **Treatment Services for Adolescent Substance Abusers** by Alfred S. Friedman and George M. Beschner — National Institute on Drug Abuse, USA 1985.

2

RULES AND REGULATIONS OF THE CENTRE

The After-care centre has certain specific goals and objectives. In order to help patients achieve these goals, certain policies are set. This chapter throws light on the rules and regulations to be followed by patients during their stay at the Centre. Rules can be modified according to the need of the specific centres.

Admission policy

Patients who have a diagnosis of chemical dependency and have already undergone primary treatment for the same are eligible for admission. Admission is done through an interview by the Counsellor.

Admission requirements

1. Should be abstinent from all mood altering drugs at the time of admission.
2. Should express willingness to get admitted.
3. Should have accepted all rules and regulations of the centre.
4. Should be between 20-40 years of age.
5. Should not suffer from any major physical illness.
6. Should have no severe physical disability/handicap.
7. Should not suffer from any major psychiatric illness.

Prior to admission, the patient is given a detailed account of the treatment policies, procedures, rules and regulations.

Length of stay

Each patient is expected to stay for a period of three to six months. Patient's length of stay is also based on his cooperation, and progress so far as the treatment programme is concerned. This includes both extension as well as discharge before stipulated time.

Rules/regulations

1. Gambling is strictly prohibited.
2. Borrowing or lending money is not allowed.
3. Violence in any form is not permitted and will not be tolerated.
4. Sexual relationships are strictly prohibited.
5. Patients should not form groups to tease, fight with or deliberately trouble peers or bully them in any way.
6. No inmate is allowed to go out without a pass issued by the authorities.
7. The new comer is not given an outpass for a period of 15 days from the day of admission, and will have to remain within the premises. After completion of 15 days, patients are allowed to go home/relatives' house for the weekend.
8. Patients are not allowed to bring other drug taking peers to the premises.

Medication policy

1. At the time of admission, all medicines have to be handed over to the Warden.
2. Patients are expected to take their prescribed medicines under staff supervision.
3. Patients are expected to meet the doctor when he visits the centre.

Free time

During free time patients can avail of all recreational facilities. Both indoor and outdoor games are available. Patients play games like table tennis, carrom and chess. Out door games include volley ball, badminton, dodge ball etc. Patients are permitted to watch T.V. programmes. They are allowed to watch films on video on Sundays. A library is open to them and they are encouraged to read books and periodicals. The patients are given an opportunity to utilise their free time meaningfully, so that they will continue to make proper use of it after their discharge.

Outpasses

Patients are eligible for out pass only on completion of two weeks. The Counsellor uses his discretion and the patients are allowed to leave the premises only when they have obtained out-passes from their respective Counsellors. The Counsellor issues out-passes also according to the number of *tokens each person has. If the patient has not returned to the After-care Centre at the stipulated time, his family/friends/ persons responsible are informed immediately.

Policy to deal with relapses

1. Patients are not allowed to use alcohol/drugs in the premises.
2. When patients return from an outing, they will be searched for possession of alcohol/drugs each time they enter the premises.
3. If a patient has used chemicals in the premises or returned after an outing under the influence of chemicals, he will not be allowed to stay inside.
4. Patients who are under the influence of chemicals will be sent immediately for detoxification. (It is useful to have a liaison with a local detoxification facility/unit.)
5. If a patient has had one relapse during his stay in the centre, he is given a warning and subsequently his out passes will be curtailed for 15 days. If the patient continues to use/possess drugs/ alcohol, he will be discharged from the centre.
6. Any other patient who is found to be involved/helping in malpractice or being aware, does not disclose it, will also have to face similar consequences.
7. During the patient's stay, the staff retain the right to check the patient's self or belongings periodically.

Discharge policy

Discharge on disciplinary grounds

– The patient is discharged when he uses drugs or alcohol for the second time on the premises or outside. On first relapse, a warning is given and on second relapse, the patient is discharged.

* 'Token Economy System' explained in detail on page numbers 21 & 22.

- The patient is discharged on disciplinary grounds if he indulges in violence, presents a danger to other patients, or resorts to stealing anything from the premises.
- If a patient does not show any involvement in the programme or if he is not willing to follow the rules and regulations, his out-passes are withheld. Repeated failure to comply will result in his discharge.

Planned discharges

Each patient will usually be ready for discharge when he has completed 3 to 4 months of stay. However, it can be shortened or extended according to his progress. Discharges are determined by the Counsellor in consultation with the patient. Prior to discharge, the Counsellor ensures the emotional and physical stability of the patient. He

- reviews the goals the patient has achieved
- plans future goals and determines follow-up steps
- makes sure that social support has been created and strengthened
- reviews relapse prevention methods and plans for management of warning signs.

On the day of discharge, a small get-together is planned, wherein the patient gives his feedback about the programme and the steps he is going to take after his discharge. The Counsellors and peers provide support and encouragement.

Additional Information

A model time table of programme

Phase I

Week Days	06.30.– 06.45	06.45 – 07.00	07.00 – 07.30	07.30 – 09.30	10.00 – 10.30	10.30 – 12.00
Monday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Reeducative session
Tuesday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Assignment on reeducative topic
Wednesday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Reeducative topic
Thursday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Assignment on reeducative topic
Friday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Reeducative topic
Saturday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Assignment on reeducative topic
Sunday	FREE					

* Assignments on each Reeducative topic given on Pages 230 to 235.

Phase I

12.00 – 01.00	01.00 – 02.00	02.00 – 03.30	03.30 – 04.00	04.00 – 05.00	05.00 – 06.00	06.00 – 06.30	07.00 – 08.00
Ind. Coun selling	Lunch	Group Therapy	Tea	Coun-selling	Games	Tea	AA Meeting
Supportive Group	Lunch	Group Therapy	Tea	Coun-selling	Games	Tea	Reeducative topic
Group Assignment	Lunch	Group Therapy	Tea	Relaxation Therapy	Games	Tea	NA Meeting
Ind. Coun-selling	Lunch	Group Therapy	Tea	Coun-selling	Games	Tea	Reeducative topic
Individual Assignment	Lunch	Group Therapy	Tea	Coun-selling	Games	Tea	Life History sharing
Family Counselling	Lunch	Group Therapy	Tea	Coun-selling	Games	Tea	Life History sharing

FREE

Additional Information

Phase II

Week Days	06.30 – 06.45	06.45 – 07.00	07.00 – 07.30	07.30 – 09.30	10.00 – 10.30	10.30 – 12.00
Monday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Therapeutic Games
Tuesday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Assignment
Wednesday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Therapeutic Games
Thursday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Therapeutic Games
Friday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Review of the Week
Saturday	Physical Workout	Prayer (Thought for the day)	Home Maintenance	Bath/ Washing/ Breakfast	Community Meeting	Review of the Week
Sunday	FREE					

Phase II

12.00 – 01.00	01.00 – 02.00	02.00 – 03.30	03.30 – 04.00	04.00 – 05.00	05.00 – 06.00	06.00 – 06.30	07.00 – 08.00
Ind. Coun selling	Lunch	Group Therapy	Tea	Coun-selling	Games	Tea	AA Meeting
Supportive Group	Lunch	Group Therapy	Tea	Coun-selling	Games	Tea	Reeducative topic
Therapeutic Group Activities	Lunch	Group Therapy	Tea	Relaxation Therapy	Games	Tea	NA Meeting
Therapeutic Group Activities	Lunch	Group Therapy	Tea	Coun-selling	Games	Tea	Reeducative topic
Therapeutic Game	Lunch	Role Play	Tea	Coun-selling	Games	Tea	—
Family Counselling	Lunch	Free	Tea	Coun-selling	Free	Tea	—

FREE

Games include outdoor (Shuttle, Volley Ball)
indoor (Table Tennis, Carrom, Chess)

Once in three months tournaments will be held and prizes will be given to the winners.

3

AFTER-CARE CENTRE AND AFTER-CARE SERVICES

After-care Centre provides supportive environment in a home like atmosphere to persons who have completed primary treatment for their chemical dependency. The After-care Centre is an important component of the continuum of addiction treatment services. This section gives an overall picture of the After-care Centre and discusses in detail all the therapeutic issues that go into the development of the After-care programme.

Description of an After-care Centre

Physical structure-Residential facility

- Situated in a residential area
- Spacious house with adequate living amenities, good ventilation and light
- Rooms for therapeutic activities
- Space for out-door recreations

Appointment of staff

- **Programme coordinator**

  The Programme coordinator is in charge of all the activities (both administrative and therapeutic). He should have completed post-graduation in Social Work or Psychology.

- **Psychiatrist/Medical officer**

  A psychiatrist or a medical officer works on a part-time basis and reviews the physical condition of the patients atleast thrice a week.

- **Counsellors**
  The minimum number of Counsellors required to run an after-care programme of 20 beds is 3. All the Counsellors should be post-graduates in Social Work or Psychology. They should have undergone specialised training in addiction treatment.

- **Warden**
  The Warden should necessarily be a middle-aged man and the post is a residential one. He should be a graduate in humanities or should be an active A.A. member with a history of qualitative sobriety for a minimum period of 5 years.

- **Occupational Therapist**
  The occupational therapist should be a graduate, with a diploma or degree in rehabilitation science. He should be familiar with the community resources available to help the clients in vocational rehabilitation.

- **Ward Boy**
  The Ward Boy should be an energetic young man, and should have passed S.S.L.C. or its equivalent.

- **Cook**
  The cook should be literate with sufficient experience in cooking food and proper maintenance of kitchen.

- **Security**
  To ensure round the clock service, reliable security staff are recruited.

In the selection of staff for the After-care Centre, certain specific issues must be looked into. The person

- Should not use alcohol/drugs.
- Should not have too many unresolved conflicts.
- Should not gamble.
- Should not be susceptible to bribes.
- Should not be involved in illicit sexual relationships.

Before appointing the staff, a thorough investigation of the candidate, especially with regard to the above issues should be carried out. Stability in work record/married life and good interpersonal relationship are essential prerequisites of the candidates.

Therapeutic programme

Goals

- Strengthen the motivation to lead an alcohol and drug free life
- Provide an atmosphere that will sustain the individual's desire for recovery.
- Help patients identify and manage relapse warning signs.
- Guide them to be assertive and say 'NO' to drugs.
- Help them to relearn skills necessary to cope with ordinary stresses of social interaction.
- Provide vocational skills training/opportunities for employment continuation.
- Make them realise the need to strengthen family relationships.
- Expose them to new positive ways of having fun.
- Provide model and peer experience that will enhance and improve inter-personal relationships.
- Create an awareness about the personal defects of character and a need to make positive changes.
- Help them reorganise their value system.
- Guide them to express and deal with emotions appropriately.
- Teach methods of managing finances.
- Provide opportunities to learn responsible living.

Programme

The therapeutic programme is conducted in two phases.

First phase

The duration of this phase is one month. During this period, the patient attends re-educative sessions on various topics related to chemical

dependency. After each session, he is given assignments related to his problems. Individual counselling, based on an individual treatment plan is given to each patient.

Group therapy is also conducted every day. Patients are provided opportunities to participate in recreational activities. They learn relaxation methods to manage stress. They also attend A.A./N.A. meetings.

The process adopted to carry out these activities of the therapeutic programme is discussed below in detail.

Prayer, community meeting, thought for the day

This meeting is where the patients get together and share their feelings, thoughts and experiences along with the Counsellor.

At 10.00 a.m., a bell is rung for the patients to assemble. They sit in a circle. The day starts with this meeting and it lasts for half-an-hour to 45 minutes. All therapeutic staff participate in the meeting. The meeting begins with the Counsellor asking someone to volunteer and say a prayer or sing a song. The Counsellor reads a thought for the day. Patients are asked to reflect on that thought and are given an opportunity to express their own experiences or views relating to that particular thought. Patients are encouraged to talk only about themselves - use 'I' and not 'We' or 'You'.

A person sometimes may not have anything to say. He must however introduce himself and say that he has got nothing to communicate. The Counsellor discourages him from just nodding his head or gesturing to say 'no.'

The staff also introduce themselves and say a word or two. This should be an honest expression of self and is not meant to be a preaching session to patients.

At the close of the meeting, everybody meditates for a few minutes.

The Community meeting is an opportunity for the Counsellors and patients to share their feelings and get to know one another. The Community meeting instills faith in a Higher Power and provides

an opportunity for the patients to start the day on a right note. The thought for the day* makes the patients think meaningfully and plan their day better.

Re-educative sessions

The re-educative lecture sessions are held everyday for the patients. It lasts for 45 minutes to one hour. The lectures focus on the problems faced by chemical dependents and offer guidelines and methods to deal with those problems.

The lecture sessions are conducted by the Coordinator and Counsellors. In the first phase, the following lectures are covered.

Disease concept	Grief and fear
Denial	Shame and guilt
Understanding values	Dry-drunk syndrome
Relapse prevention planning	Assertiveness
Overcoming grief	Human needs
Steps towards sober living	Stress management
Anger	Problems in sobriety
Hurt feelings	Personality defects

These lectures are not theoretical. They provide information and are followed by discussions. These interactions centre on the patients' problems and focus on realistic methods to deal with them. Specialists may be invited, to give lectures on topics relevant to the patient's recovery (for example, Nutrition, Budgeting).

Assignments

After each session, the patients are given assignments related to the lecture topics. Assignments help the patients to think, reflect on and analyse the facts presented during the lecture sessions. These strengthen their knowledge and give them an opportunity to look at their personal experiences/problems. They become aware of the methods they could adopt to manage their problems.

* A few thoughts that could be read in the community meeting are given as additional information.

Group therapy

The other important component of the therapeutic programme is group therapy. Group therapy may be held every day between 2.00 and 3.30 p.m. Group therapy is conducted by the same Counsellor for one week.*

Counselling

Chalking out an individual treatment plan and offering individual counselling based on it are the important components of this programme.•

Family programme

Involvement of family members is crucial in recovery. Family members visit the After-care Centre once a week. They have individual and combined counselling sessions.

Life history sharing

Patients are encouraged to share their life experiences. The new comers share their life history on completion of 15 days, so that they are familiar with others and feel comfortable enough to share openly. A few guidelines which may be given are

- start from your childhood, stating any significant event from your childhood to your adolescence.
- say when and how you started using alcohol or drugs, and the pattern of use.
- share about the damages caused by drugs to your physical, emotional, occupational, social and family life.
- share how you came to this centre, the initial feelings with which you entered the centre and your present feelings.

Supportive group

The Counsellor conducts the supportive group once a week. Here any complaints to be made, any grievances, suggestions are brought forth

* For further details refer Chapter 19.

• More information on this is given in Chapter 20.

and discussed. Interpersonal problems are also handled. The ground rules to be followed are

— no accusation to be made.
— no judgements to be passed.
– complaints to be descriptively and specifically stated.

Relaxation therapy

Stress management is part of the programme. The Jacobsons progressive relaxation methods* can be followed. In case the Counsellor is familiar with any other methods, he could make use of them. A weekly session would be adequate.

Therapeutic games

In order to help the patients relax, a few games are also introduced. These games not only help patients fulfill their recreational needs but also enable them to understand themselves better in the process.

Recreational/Leisure time activities

Throughout their 3 months' stay at the After-care Centre, patients are encouraged to spend their leisure time constructively. Facilities to play indoor games (Chess, Chinese Checker, Table Tennis, Carrom, etc.) and out door games (Shuttle Badminton, Volley Ball, Dodge Ball, etc.) are provided. Tournaments are held every 3 months and prizes distributed. Patients are also encouraged to utilise the library during their free time.

Participation in A.A./N.A. meetings

Patients are expected to attend A.A./N.A. meetings regularly. This helps them to strengthen their recovery.

Second phase

This phase of treatment lasts for two months. During this phase also, patients attend re-educative lecture sessions which focus on improving their quality of life. Intensive group therapy and individual counselling

* For more details refer 'Alcoholism & Drug Dependency - A Professional's Master Guide'.

are provided. The individual treatment is restructured after feed back and review. Opportunities are provided for vocational training. Patients start attending office during day time. During this phase also, opportunities to participate in recreational activities are provided. Patients continue to attend A.A./N.A. meetings.

Role play

Role play is intended to help patients handle high risk situations which they may be required to face after leaving the centre. High risk situations include both internal and external cues. These are enacted and discussed in role play sessions. Internal cues would include craving, anger, resentment, loneliness, depression, anxiety, fear of failure, boredom, etc. External cues would include a drinking party, meeting an old drinking/drug taking companion, friends calling for a drink or taking drugs, suspicion from others, excessive money in hand etc.*

Duties

Therapeutic duties are allotted to each patient. One person will be selected as a monitor to ensure that duties are carried out properly. Duties include all activities essential to maintain the centre. For example — ringing the bell, filling water jugs, dusting, cleaning ash trays, washing vessels, cutting vegetables, watering plants, maintaining the recreation room, prayer hall, etc. New comers are allotted easier tasks to help them get acclimatized to the routine. Any problem faced, any patient not doing his duty etc., are handled either in the supportive group or when duties are changed. The duty roster is put up on the Notice Board every week. To encourage participation, the Token Economy System is implemented here.

Behaviour therapy – token economy system

The Token Economy System has been found useful in increasing patient participation in the programme and to bring about desirable behaviour changes. It is introduced in the first week itself. Participation in various activities, physical work out, doing allotted duties, attending lectures, group meetings etc., help patients earn their tokens and rewards. The following format will serve as an example:

* The chapter on **'Assertiveness Training'** deals exclusively with these issues and offers meaningful methods to tackle them.

Tokens	Specifications	Rewards
Green	Reporting on time and being regular for physical work out.	Out pass for two hours OR
	Executing duties with involvement	Allowing him to watch the weekly special programme 'World This Week' on the T.V. OR
	Taking initiative to do extra work	Preparing a dish of his choice
White	Submitting assignments on time	Out pass for week ends OR
	Open and honest sharing in group therapy	Allowing him to see a movie of his choice OR
	Being supportive and understanding towards new comers	Permitting him to possess and use 'Walkman' during weekends

Therapeutic group activities

The activity hour is a vital component of the therapeutic programme. It is an informal meeting of patients and Counsellors, who engage themselves in discussions, games, activities etc.

Thus the After-care programme aims at helping the patients lead a long-term, drug-free, qualitative life. This goal can be achieved through a carefully planned treatment programme which effectively combines in itself the various methodologies described so far.

Additional information

I. A few thoughts for the day

Just for today

I feel weighed down and depressed when I think that I have to lead a changed life pattern for the rest of my life. I have tried this so many times in the past and failed miserably.

I am reminded of a clock that came to know it had a 2 year guarantee period. The very thought of striking 6,30,72,000 seconds made it absolutely tired and so it stopped. Another clock noticed this and pointed out that it was happy it had to tick only once every second.

I learn a lesson from this and tell myself that I will concentrate on living a new way of life 'Just for today'. This 'Today' programme applies to all areas of my life. If I find executing my plans for 24 hours difficult — if I find myself going back to my old ways of thinking — I will plan for 10 hours. If I feel even this too much, I will plan for one hour...one more hour..and so on.

All that I really have is 'Now'. Yesterdays are gone; I have to forget them. Tomorrow has still not come. Therefore, I need not worry - I plan for today - JUST FOR TODAY. When I implement this 24 hours plan, I obtain peace, assurance and happiness.

I pray to God to help me work the 'One day at a time' programme to the best of my ability.

The first drink does the damage

After treatment, do I want to drink a little alcohol? With that, all my problems start again. This is a fact which I have learnt from experience. Before I realised this, I had made several attempts to become a controlled drinker and failed.

When a stone rolls down a mountain, even if the mountain wishes, that stone cannot be stopped from rolling. Similarly, the first drink will inevitably lead me to excessive drinking. Even if I wish, it will be difficult for me to stop. If I start drinking, I will get caught in many

problems without my knowledge. In the end, I would be at cross purposes with my career, family, friends etc. This is the bitter truth.

So what do I do when I experience a craving to drink? I have to recollect in detail all the problems I had encountered - the job I lost, the lack of love from my children, the problems in my marital relationship. When I recollect these, I will experience anxiety and fear. The thought of drinking would automatically be removed from my mind.

I clearly understand the truth. I start with the intention of having only one peg. I plan, but am unable to stop with that first drink. I lose control. So, I have to avoid that first drink.

I pray to God to keep me away from the self-deception that I might gain control again.

Developing patience

Some happy children sowed a few seeds in the garden and poured water. After doing this, they went back home. All of them were so happy and excited that they hardly slept that night. They waited for sunrise, and came running to the garden. They expected the garden to be filled with blossoms, and were disappointed. Not even one plant had grown; not even one flower. The children were very upset, disappointed, and sad. They went back home and did not come back to the garden afterwards. They did not pour water and so all the seeds dried up.

If, like these children, we expect immediate results, we will only be disappointed. Sometimes, even after repeated efforts, we may not be able to get the results we want. When we stop drinking and want to lead a sober life, there may be many problems threatening us. We cannot expect to set right all these problems immediately.

If I expect to solve all the problems immediately, I am going to be disappointed. I have to plan one day at a time and start building my sobriety. For this, I need patience and self determination. I pray to God to give me the strength to develop patience.

Sharing with others

When I was drinking, I was always thinking only about myself. I had no other thought. When I got up in the morning, with a bad

hangover, my only thought would be how to get rid of this hangover. So what did I do? I started drinking again. I did not remember or think of anybody else other than me and my bottle. Living for others, was a value which was of no meaning to me.

A male elephant and a female elephant were very thirsty and were searching for water in a forest. Suddenly, they found water in a small pond. Immediately, the female elephant requested the male elephant to drink, but the male elephant insisted that only if the female drank, would he drink. After a few minutes, the two elephants decided that they would each go to one end of the pond and drink half the water. Both the elephants put their trunks into the pond and stood, but the level of water never came down. Why? The female elephant waited for the male elephant to drink whereas the male elephant waited for the female elephant to drink.

What does this story tell us? Life becomes meaningful only with sharing. When I give in and sacrifice a few things for others, I find a meaning for my existence. Thus, I should avoid thinking only about myself and must start being concerned about my family and friends. I pray to God to give me the strength to stop being selfish and start living for others.

Seeing good in others

A little boy, not familiar with the echo, went to a forest. He thought he heard the voice of another boy not very far off.

He shouted, "Hello, there!" and the voice shouted back, "Hello, there!"

He cried at the top of his voice, "You are a mean fellow!" and the cry came back, "You are a mean fellow!"

The boy got upset, went home and told his mother that there was a bad boy in the woods. The mother understood that it was an echo, and said, "Ramu! speak kindly to him, and he will also be kind to you!"

The little boy went back to the woods and shouted, "You are a good boy!" Out came the echoing reply, "You are a good boy!"

"I love you" - he shouted happily.

"I love you" - replied the faithful echo.

The story of echo is exactly the story of our lives. We receive only what we give. If we show love and understanding to others, they give back care and concern. On the other hand, if we show anger and resentment, we will receive only negative criticism and hatred.

I pray to God to give me the strength to see all the good qualities of others, which, in turn, will help me to be more loving, kind and balanced.

II. A few therapeutic activities

a) Completing developmental tasks

Following is an activity which the Counsellor can ask the patients to participate in. This will create an awareness in them as to what tasks they have failed to complete in their different 'life-stages' as a result of their chemical dependency. If an awareness is created they can be guided to complete the tasks from then on.

There are a series of developmental "tasks" appropriate to different stages in a person's life. A developmental task is one which arises at or about a certain period of the life of the individual. Achievement of the task leads to happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by society and difficulty with later tasks. A chemical dependent would not have completed most of these developmental tasks. So it is essential that he becomes aware of the tasks he is expected to complete.

Description of the activity

In the beginning of the session, the patients are divided into three groups. The first group comprises patients between 18-26 years, the second, 26-38 years, and the third, 38 years and above. The Counsellor writes down on the board the developmental tasks for the respective age groups.

a) Tasks for the age group 18-26 years are:
Completion of school education and entry into college.
Completing college education.

Selecting and preparing for an occupation.
Developing the ability to make decisions.
Achieving Socially acceptable behaviour.
Understanding values and living by them.
Preparing for marriage and family life.
Building a good relationship with family members.
Managing finances responsibly.

b) The tasks for the age group 26-38 years are :
Getting started and settling down in an occupation.
Selecting a life partner.
Having a good relationship with the marriage partner.
Starting a family.
Rearing children.
Managing a home.
Finding a congenial social group.
Learning healthy recreational activities.
Managing to save money.

c) The tasks for the age group 38 years and above are:
Maintaining or improving one's standard of living.
Assisting children to become responsible happy adults.
Relating well with the spouse.
Planning and saving for the future.
Establishing a satisfactory residential living arrangement.
Developing trust in God.
Learning to do activities with the family members.

Patients are given 10 minutes to read the tasks. Then a patient from the first group sits facing the three groups and the patients from the other group ask him questions with regard to the tasks mentioned on the board. (Questions such as "How educated are you?", "Did you complete your studies?", "Are you married?" etc.) The group supportively helps the patient realise the tasks he has not completed. The patient is helped to prioritise and establish a goal to be achieved. The group members then help the person chalk out a plan of how to achieve it. Every patient has his turn.

At the end of the session, the Counsellor educates the patients on the importance of developmental tasks and their completion. He makes them understand that they enhance one's quality of life.

b) Living by Values

Values form the core of a person's life. They are learnt and followed from childhood, and they determine the quality of a person's life. During the different stages of his dependency, the chemical dependent would have broken all the values he had previously learnt. So, during recovery, it is essential for him to understand the necessity to rebuild his value system, and start living by it. The following activity will help in creating an awareness in him and providing him with a structured plan to start living by values.

The Counsellor may ask the chemical dependent to list the values he wants to follow in the order of his priorities. After the prioritising is done, he may be asked to explain each value as given below:

1. **Loving**
   - Showing care, concern and understanding of others' needs and emotions.
2. **Being Honest**
   - What the person thinks, says and does - all the three are in a straight line. They are in perfect harmony with each other.
3. **Disciplined**
   - In thought, speech and actions. Discipline applies not only with regard to overcoming craving for and consumption of alcohol/drugs. It means discipline in every area of life.
4. **Being Responsible**
   - In every area of his life (occupation, duties to family, society etc.).
5. **Drug-free life**
   - Leading a life free from all mood altering chemicals.
6. **Hard working**
   - Working with involvement, interest, enthusiasm - working to the best of one's abilities.
7. **Open mindedness**
   - Listening whole heartedly.
   - Sharing one's feelings openly.
   - Accepting and acknowledging good things in others.

Now he should explain to the Counsellor as to what steps he is going to take to practise that value. For example, if his first priority is 'hard work', he should state as follows

- I will clean vessels regularly
- I will do all the jobs assigned to me
- I will participate with involvement in the therapy classes and so on.

The person should start practising the value he has prioritised, and share with the group members and the Counsellors as to how exactly he displayed that value in his life during that week. Group members provide a feedback. It will be a repeat exercise for every week. This will be a constant reminder and a conscious practice for him so that when he leaves the After-care Centre, it will become a permanent habit.

c) 'Strengthening Self-esteem'

Self-esteem is actually our assessment of our own self. It is essentially a measure of self worth and importance. Only a person with a strong self-esteem will be able to build meaningful relationships and find himself successful. A chemical dependent, during the different stages of his disease, would have felt incapable, unworthy and low. His self assessment would have been a negative one.

So, during recovery, it is very important for him to strengthen his self-esteem and improve the quality of his life. He has to understand that self-esteem is a quality that can be strengthened at any point of life regardless of age, educational background and social standing.

The 'self-esteem' game is a useful exercise to help the patients strengthen their 'self-esteem'. Each patient during his turn sits in front of the others. Each member of the group is expected to state atleast one good quality which he had noticed in that person. While sharing or giving the positive stroke, it should be ensured that the member

- maintains eye contact
- feels comfortable
- is genuine about what he is sharing.

The game proceeds, and as each member of the group is focused on, all others give positive strokes to that member. This activity helps the clients to receive and give positive strokes comfortably.

Some therapeutic games

1) 'Sober living' game

This activity helps patients to discuss various methods to stay sober.

Description

At the beginning of the game, every patient is given a piece of paper in which one of the methods to stay sober is written. Twenty pieces of paper each containing one method are distributed among the patients. Some methods are

Staying away from the first drink/drug.
Living one day at a time.
Diverting the mind.
Postponing the first drink.
Going to a place where drugs cannot be used. (Library, temple, prayer hall).
Remembering happy moments sobriety has brought forth.
Getting active physically.
Contemplating on the serenity prayer.
Changing old routines.
Availing a sponsor.
Fending off loneliness.
Recognising anger and resentments.
Remembering the worst drinking episode.
Eliminating self-pity.
Staying away from friends who are continuing to use drugs/drinks.
Keeping regular contact with the treatment centre.
Taking antabuse everyday.
Regular eating habits.
Involving in healthy activities (e.g. going to temple, playing games).
Sharing with someone trustworthy.

The patients sit in a circle. Anybody can start. Each patient reads aloud the method given to him and shares his experiences about it. Others ask questions, and they discuss the method in detail.

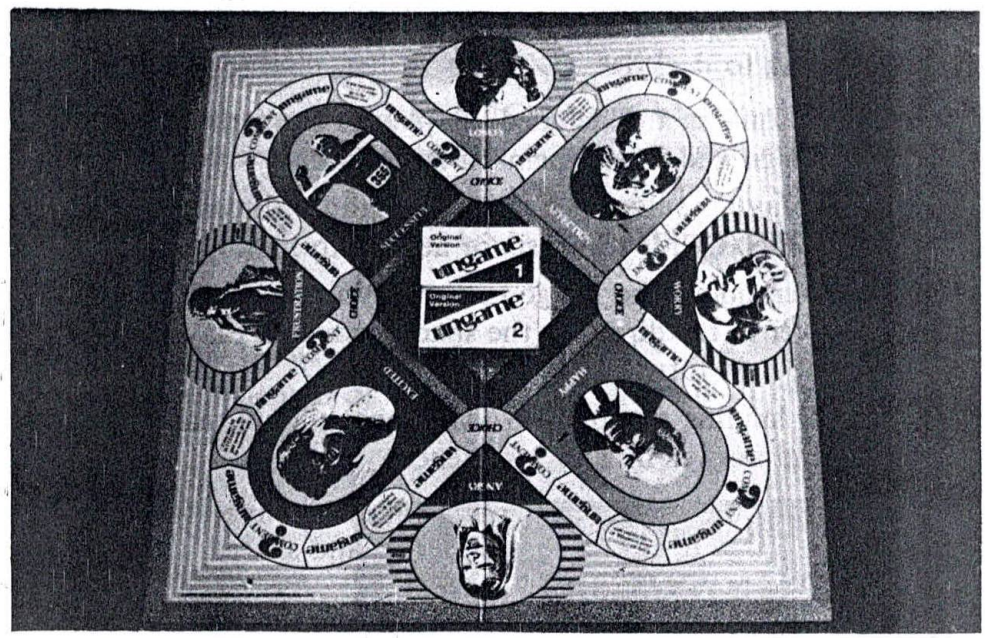
This game teaches clients practical tips for sobriety. A sense of hope is instilled, and some clarity is achieved with regard to management of 'high risk' situations.

2) 'Self expression' Games

As the name indicates these games help the patient to talk about his emotions comfortably, meaningfully and in depth.

i) Ungame

This is a board game similar to ludo/snakes and ladders. The dice is thrown and each player moves his coin that many squares. At particular intervals each square would have particular feelings written on it.



If the player's coin lands on this special square with the name of a feeling written on it - say anger, resentment, happiness, anxiety, fear etc., he will have to share an event from his life which involves the feeling during that day or week. Ungame facilitates patients to express their feelings openly.

Rules and Regulations

1. Determine the length of playing time. For optimum results, 45 minutes to 1 hour is suggested. Extra time may be desired at the conclusion of the game for talking about the experience.

2. Players agree to REMAIN SILENT except during their turn. To encourage LISTENING and UNDERSTANDING and to discourage probing and challenging.
3. Players should have pencil and paper to jot down their personal thoughts and/or questions to ask other players, to be used at the appropriate time. (see 7 & 8 below)
4. Select the Deck to be used. Deck 1 contains LIGHTHEARTED topics. A great ice breaker or fun way to get acquainted. Deck 2 deals with more SERIOUS subjects. This deck works better after a group is acquainted and has practised sharing, listening and responding to deck 1.

Note: Blank squares are included, so players can write questions of their own design and insert them on the board.

5. Each player selects a marker and places it on the QUESTION/COMMENT space nearest to him.
6. After determining who will go first, a player rolls the dice and moves his marker in the direction the spaces indicate. Player to the left takes the next turn.
7. A player landing on an UNGAME space should read the feeling aloud and answer in 2 or 3 sentences.

Remember, no other player can comment at this time! Thoughts and ideas can be jotted down on scratch paper and shared when landing on a QUESTION/ COMMENT space.

8. When landing on a QUESTION/COMMENT space, a player may

(a) Ask another player a question regarding something noted on scratch paper, something previously shared, or anything that comes to mind.

Examples: "What do you like to do in your spare time?"
"Why did you answer that question the way you did?"
"How do you feel about_____ ?"
The question may be answered at this time.

(b) Make a comment on ANY subject.

Player has the opportunity to say whatever is on his mind OR refer to what has been noted on scratch paper.

Examples: "This is how I feel regarding _____."
"I think I understand the way you feel."
"How I would answer that last question is_____."
"I really appreciate you!"
The other players listen without responding.

9. When landing on an "IF YOU....." space, the player should read the statement aloud and respond by moving to the corresponding "EMOTION" area if it applies OR staying on the space if it does not apply. Player should share his reasons.

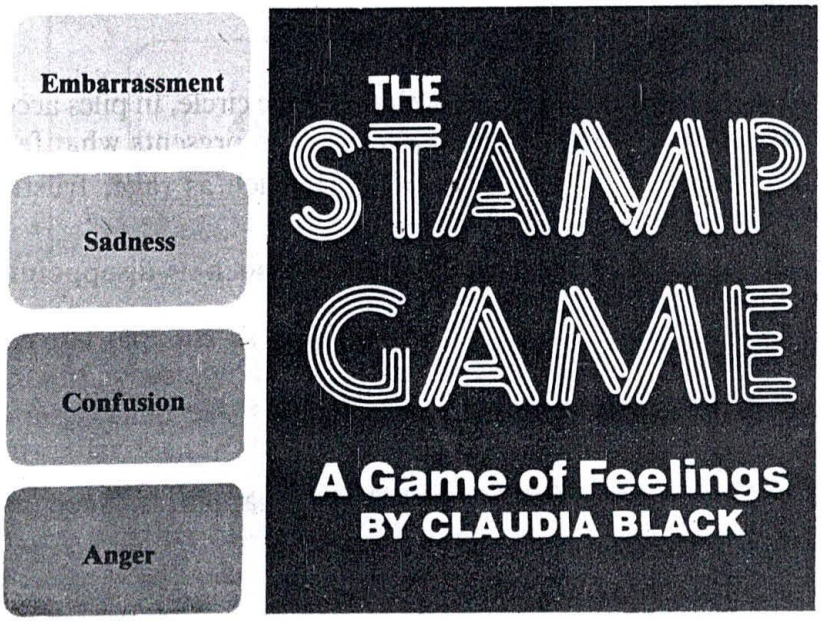
   On the next turn, the player in the Emotion area starts his/her move on the space indicated by the EXIT arrow.

10. If the player lands on a CHOICE space, he may choose whether to draw a card, ask a question or make a comment.

Note: This game can be obtained from — The UNGAME CO., Anahelm, California — 92806, USA. Alternatively, this can be made on your own.

ii) The Stamps Game

Purpose: The purpose of the STAMP GAME is to help players to identify, clarify and discuss feelings.



Leader: THE STAMP GAME requires that one person acts as a facilitator and does not participate in playing the game. This is an emotionally-charged game, and so the facilitator must be a warm, caring person, comfortable with his own feelings and the feelings of others. In this case, the Counsellor will be the facilitator.

Players: The game can be played with one to six players, with the facilitator moving among the groups.

Time Frame: A group of six players will take approximately 60 to 90 minutes to play the game. Allow 90 minutes if feedback is utilised. The STAMP GAME may be ongoing, in that, participants may play a portion of the game during each session.

Results:

- Players will be able to relate more honestly to others when they have learnt to express feelings.
- Players will begin to respond appropriately to situations when they become more aware of their feelings.
- As a result, players will become increasingly more effective problem solvers.

Setting: Game can be played on a large table or on the floor (more fun).

To Begin:

1. Players sit in a circle.
2. Counsellor places stamps in the centre of the circle, in piles according to their colour and explains which colour represents what feelings.

   RED STAMPS — Any form of anger such as rage, frustration, irritation, disgust, etc.

   BLUE STAMPS — any form of sadness such as disappointment, loss etc.

   BLACK STAMPS — Fear.

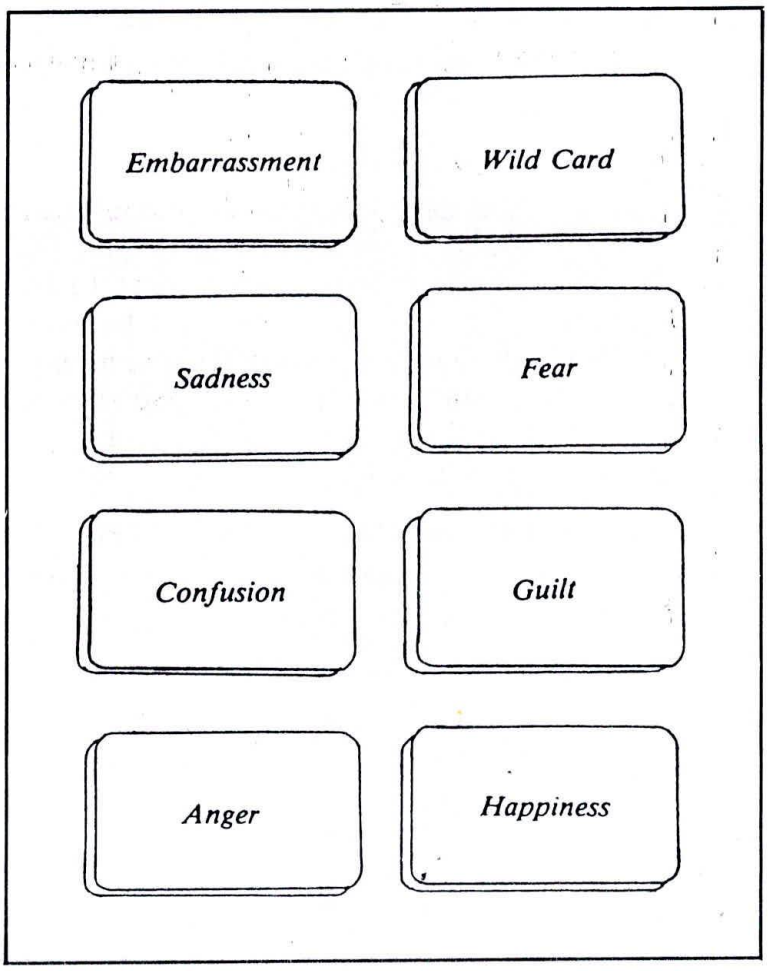
   ORANGE STAMPS — Guilt

   GREEN STAMPS — Embarrassment

   YELLOW STAMPS — Any form of happiness, such as joy, warmth, love etc.

LIGHT BROWN STAMPS — Confusion.

WHITE STAMPS (Wild card) — Any feeling not listed above, which the player wants to identify, e.g., loneliness, helplessness.



3. Ask participants to think back and bring to mind what it was like when they were young children and teen-agers growing up in their family. Then ask them to pick up stamps which represent that particular feeling they had as youngsters and adolescents.
4. Explain that the stamps represent the feelings they had. It does not matter whether other people in their family were aware of the fact

that they had these feelings. Participants should select a number of stamps representing the intensity of each feeling. Example: If a participant experienced a great deal of anger, he might take 5 to 10 red-anger stamps, compared to feeling a small amount of fear, where he might take 2 or 3 black-fear stamps.

If participants are not able to immediately identify the particular feeling, give them some more time.

(This process usually takes approximately 5-8 minutes)

5. When all group members have selected their stamps,instruct them to arrange the stamps, in an order beginning with the feelings expressed the most as a child, to feelings shown next, to those shown the least. Example: the person who knows that he hid his anger, yet found it easier to show sadness might position his blue-sadness stamp(s) before his red-anger stamp(s). The person who was afraid and showed that fear, will have his black-fear stamps in front of his orange-guilt stamps if he seldom or never showed guilt.

There is no one correct way to position stamps; arrangement is left up to each player.

Do not give any further instructions until players have completed the positioning of the game.

To Play:

As sharing is very personal, it is suggested that there is no break after the sharing has begun.

Tell participants that each one has approximately 10 minutes to share.

1. The Counsellor leaves it open for anyone to start, and when a person volunteers, asks that person to talk about his stamps with the group. It is easier for participants to begin by talking about the feelings they expressed the most, then feelings they felt but expressed less.
2. The participant tells the group the source of his feelings, rather than simply identifying them, e.g., "this anger is with my mother for all her screaming" vs. "this is my anger-red".
3. As each participant shares, members may become aware of more feelings and quietly add to their piles. Also, while the participant

is sharing, he may become aware of having more of one feeling than he originally thought and may add to his pile while speaking.

4. After the first player has shared his feelings, ask him to reflect on how the stamps are different today as an adult. Ask him to represent that change by adding to or substracting from his collection and/or repositioning the order. While he is changing his stamps, instruct him to tell the group why he is making the changes. When completed, next person takes his turn. Allot approximately 8 to 10 minutes per person for this sharing for a group of six.
5. After the last player has shared and if time permits, the Counsellor may want to ask if the first player would like to say more, as the first player to speak is often more inhibited.
6. Be sure to thank participants for their sharing and attentiveness.

It is suggested that the group ends with a quick self-reflection or self-image exercise. The following are a few suggestions:

Ask the group to quickly express to each other

A. What is it that you are particularly glad you shared?
B. What did you learn about yourself during this game?
C. What did you learn that would be helpful for you to work on?

Again, thank the participants for being honest.

Note: This Game can be obtained from — MAC Publishing a division of CLAUDJA, inc 5005, East 39th Avenue Denver, COLORADO — 80207, USA. Alternatively, this can be made on your own.

3) Memory game

A few items are kept on the table and after observation for three minutes, patients are asked to close their eyes and write down the objects they had seen, on a piece of paper. This game can be played frequently to help patients work on memory deficits which might have been caused due to alcohol/drug use. This exercise helps in developing 'new learning' as well as retention.

4

MEDICAL COMPLICATIONS RELATED TO DRUG ABUSE

Excessive and prolonged use of chemicals leads to medical complications specific to the drug abused. An awareness of the complications related to specific drugs is a must for the therapist working at the After-care Centre. As a detailed coverage of all the complications is beyond the scope of this Manual, it will be helpful for the therapist to get exhaustive information from relevant literature.

By the time a patient reaches the After-care Centre, painful withdrawal symptoms following the cessation of drug intake would have been handled and dealt with. Even then it would be a fallacy to assume that all is normal with the patient. He may need a few weeks or even months to totally recover from the damages that drug abuse has caused. In this chapter, we have dealt with the problems associated with cannabis and brown sugar addiction because these are the most commonly abused drugs in India.

Medical Complications

Respiratory ailments

Chronic cannabis and brown sugar users frequently suffer from respiratory ailments like pneumonia, bronchitis or even tuberculosis. Poor health condition, poor nutritional status combined with frequent inhalation of drugs that are irritants to the respiratory system are responsible for this. Repeated infection of the tubes in the lungs (bronchioles) damage the walls of the tubes leaving them permanently dilated. This leads to a condition called 'bronchiectasis'. All these conditions require appropriate medical treatment. With cannabis, the reduction of the white blood corpuscles in the blood lowers immunity, making the patient more susceptible to infection.

Cardio-vascular problems

Brown sugar intake leads to reduction in blood pressure and heart rate while cannabis lowers blood pressure (by vaso-dilation) and increases heart rate as much as 50%. Frequent interference with the natural balance in the body that maintains these vital signs can lead to complications.

Sexual problems

Narcotic use has been frequently associated with reduced libido. Studies have shown that the sex hormone level correspondingly declines with the increase of THC (the mood changing chemical in cannabis) in the blood. Thus sterility and impotence can accompany drug abuse.

Problems with memory

Memory is the ability to recall past experiences or information stored in the brain. Memory is of three types.

1) Immediate memory (dialling a telephone number after a glance at the directory) Here the information is retained for a very short time and then forgotten. Recall within this time frame is instantaneous.
2) Short-term memory involves remembering newly learnt material. The information is stored in the brain and needs a few minutes for recall.
3) Long-term memory involves memory relating to events dating back for many years and is stored. The information is retained life long. The recall time is immediate.

All the three patterns of memory and recall depend on the functioning of the pathways in different parts of the brain. Use of drugs can and does affect memory by affecting the integration, interpretation, storage and retrieval of information. In addition to this, deficiency of Vitamin B-1 (due to poor nutrition) complicates matters further.

Of the three, short-term memory is the worst affected. So, there is difficulty in learning new material and in storing new information. This becomes significant because the drug dependent person finds it difficult to cope with expectations at school/college. In vocational training also, learning a new skill becomes difficult.

Poor short-term memory persists for a few months following cessation of drug use. Since there is little that can be done medically for the patient, reassurance by the Counsellor becomes very important. These deficiencies that are threatening during the early days of recovery, gradually disappear as abstinence continues. Exercises to improve memory and concentration are quite helpful.

Sleep disturbances and poor appetite are the most common complaints of drug dependent people. Sleep disturbances are most upsetting to the patient. This condition may be an indication of an underlying psychiatric problem and therefore this possibility has to be ruled out first. In the absence of such problems, a structured life style with adequate physical exercises is enough to handle this problem.

Lack of appetite is the result of the chemical dependent's poor eating habits. Providing input to the patient on the need to reorganise his food habits, along with the use of some enzymatic preparations to increase appetite, often help.

Complications with intravenous drug use

a) Sharing of unsterile needles can lead to infective hepatitis (jaundice — loss of appetite, vomiting and malaise). Medication, adequate rest and diet control are required. If special arrangements cannot be made for this patient, he may be temporarily sent home until his medical condition improves.

b) Acquired Immuno Deficiency Syndrome (AIDS) : Sharing of needles with HIV positive drug abusers can lead to infection that later on results in AIDS. Sharing of needles accounts for one fifth of all AIDS cases. If facilities are available, the Counsellor should convince the intravenous user to take the ELISA screening test to rule out HIV infection. If the result proves negative, the potential risks involved in drug use should be clearly explained to the patient. If results are positive, supportive counselling, reassurance and information on preventing the spread of infection to others are necessary.

c) Repeated use on same injection sites or use of unsterile needles can lead to injection abcesses at the site, lung abcesses or abcess in the brain. It should be left to the discretion of the physician to decide if the patient can be treated while at the After-care Centre itself or if he has to be shifted to a Hospital.

Overdose

If the patient has a relapse, he may unwittingly take an overdose of heroin. The body may become cold, blue and moist. Fits, shock and coma can follow. Respiratory arrest is a possibility. Immediate medical help is necessary to prevent death.

Psychiatric complications

In most cases, it is difficult to ascertain if the psychiatric condition preceded or followed drug abuse. Whatever be the origin, it is clear that such complications can exist in the recovering person. Often, these problems are secondary to the main problem of addiction. With low doses of medication and a period of abstinence, improvement is seen. Sometimes, the psychiatric problem may be primary and addiction, only a secondary problem. With these patients, regular and continued use of psychiatric medicines becomes absolutely important.

Given below are some problems that may co-exist with addiction. A few characteristic symptoms along with methods to handle them are also stated.

Anxiety

Anxiety states and panic attacks are more often associated with cannabis use than with other drugs. The patient complains of palpitation, constricted feeling in the chest, breathlessness and excessive sweating.

Mild anti-anxiety agents, use of relaxation therapy and counselling on trigger factors, help.

Depression

Patient seems dull, and shows little or no interest in interacting with others, in eating and in personal appearance. Poor or excessive sleep and lethargy are also reported. Suicidal thoughts may be present.

The patient will need medications (anti-depressants) for three to six months depending on the severity of his problem. If suicidal thoughts are present, it will be advisable to shift the patient to a hospital where 24-hour close supervision is possible.

Manic-Depressive psychosis

1 to 2% of drug abusers may have manic or depressive features. While most of these patients have only manic or depressive features, some go through swings from a depressive state to a manic state and revert back.

Restlessness, sleeplessness, excessive / rapidity of speech, jumping from one topic to another, grandiose talk, extravagant spending, dressing in bright flashy colours are some of the main indicators of the manic state.

Psychiatric consultations and continued use of medications are extremely important.

Major psychosis

Paranoid features are most frequently seen. The symptoms may range in their severity from a single paranoid delusion to a full blown paranoid schizophrenic state.

Delusions and hallucinations can also set in.

With such conditions, medical intervention is the first line of treatment. Regular use of medications for a continued period of time and supervision to ensure smooth progress are important.

Psychological testing

It would be helpful for the Psychologist/Psychiatric Social Worker to run a mental status examination on every patient admitted to the After-care Centre. It is advisable to avoid admitting patients with psychiatric disorders. The main areas to check would be:

> appetite, sleep, weight change, personal hygiene, psycho-motor activity, thought (content, relevance and coherence, delusional ideas, delusions), perception (hallucination), affect (subjective, objective), cognitive functions (memory, attention, concentration) and insight.

Simple Psychological tests to identify depression, and screening for other problems (like MMPI, MPQ) may be used.

Ongoing medical assessment should be part of the treatment programme at the After-care Centre. Even if the patient's problem is purely a medical one, medication alone will not suffice. Reassurance and support from the Counsellor who understands the condition and its future implications, aid in speedy, sustained recovery.

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5

RESOLVING GUILT AND SHAME

The emotional response to addictive illness has its roots in feelings of guilt and shame. Both guilt and shame lead to feeling **bad** — feeling bad about one's **actions** in the case of **guilt,** feeling bad about one's **self** in the experience of **shame.** Guilt results from a violation, a transgression, a fault of **doing** something. Guilt leads to a feeling of wrong doing, a sense of wickedness (**"not good"**)

Shame is the fear of being exposed, the fear of being found out. It is the fear of appearing vulnerable, of being imperfect, of having one's secrets and flaws revealed. When the chemical dependent feels ashamed, he feels intensely, painfully guilty about being himself. And feelings of not being good enough, of not doing enough, of not being right or doing the right thing are common among them.

Shame results from a failure, a falling short, a fault of **being**. Shame leads to a feeling of inadequacy, a sense of worthlessness (**"no good"**).

Guilt and shame are accented differently. Feelings of guilt place emphasis on the act committed.

"How could I have **done that**?"

Shame, on the other hand, focuses on the person who committed the act.

"How could **I** have done that?

How worthless **I** am!"

Guilt and shame are ultimately self-induced anxiety states that reinforce the chemical dependent's old feelings of unworthiness.

Unresolved guilt and shame often lead to feelings of depression and a low self-esteem. Guilt and shame are often intermingled. Guilt is the feeling of extreme regret for the past behaviour. It arises from breaking or twisting some 'rule'. Shame occurs when a self-expectation is not reached.

Many chemical dependents feel worthless and lacking because they have fallen short of their personal code of ethics. This results in a sense of self-inadequacy. They may intellectualise their feelings and will make it appear that their reaction is a result of someone else's fault.

> *Shankar had borrowed money from almost all possible sources. He did not know how he was going to repay. He blamed his wife and held her responsible for his indebtedness. His argument was that she had unnecessarily shifted her son to a more expensive school, as a result of which he had to borrow money.*
>
> *He got irritated because his wife did not bother about the crisis he was facing. He even threatened her that if she continued to be unhelpful, he had no other option but to go back to drinking.*

Many chemical dependents see themselves as victims of others' behaviour. Parents may be blamed for being too strict; wives may be charged with not making the effort to understand. Stress at work or boredom due to unemployment are other alibis used. They will keep on blaming others and also become highly sensitive to others' criticism and a small trigger, like somebody calling them a 'drunkard', will be reason enough for them to get provoked and go back to drinking.

Addiction would not be a problem for most patients if they did not suffer from any guilt, because then there would be no conflict. It is this feeling, resulting from a niggling awareness of pain caused to others, that often brings reality to the fore, and instigates recovery. Many chemical dependents feel guilty during abstinence because it is only then that they realise that during their drinking or drug taking days, they had behaved in ways which were not acceptable to them now. The chemical dependent's behaviour under the influence of drugs can be embarrassing, worrying and extreme. Mood altering chemicals lower inhibitions, and the person behaves in totally unacceptable ways. He breaks promises, forgets about appointments, his work is sporadic. He is not dependable. He becomes self-centred, insensitive to others, irresponsible, manipulative and dishonest.

Arun was abusing Ganja for the past five years. He was living with his aged mother who was struggling to run the family. She had problems with her vision. She was hesitant to consult a doctor since she did not have enough money. One day, someone told her that there was going to be a free eye camp in the village on a Sunday after two weeks.

Arun's mother passed on the information to her son and requested him to take her to the camp for treatment. Arun agreed to accompany her on the day of the camp. She kept reminding him everyday.

On Saturday night, she again reminded Arun, that they had to visit the camp the next day. Arun promised that he would take her the next morning. But when the day dawned, Arun was not found inside the house. He had gone out to the 'den' to meet his old friends. They smoked ganja together and he totally forgot the word he had given to his mother. He reached home only in the night and did not bother about how he had behaved.

Because of Arun's total irresponsibility his mother had to suffer for one more year, since the next free eye camp would be held only in the following year.

During abstinence, when he is no more under the influence of anaesthetizing drugs, he is able to see the reality of his actions, reactions and all the consequences of his appalling behaviour in the past. This is an extremely painful discovery for him and he is thoroughly shocked and ashamed. He experiences shame and guilt in magnified proportions. Actions done under intoxication, harm done to family members, friends and relatives, acts of violence, and secret guilt feelings arising out of deviations from normal values, like having extra-marital relationships, acts of dishonesty - these literally shake him.

"Oh God! How cruel had I been!
What am I going to do now?
How am I going to make amends?"

The load of guilt and shame, is too heavy for him to bear. He finds only two options before him. He starts using drugs again to anaesthetize

emotional pain and escape from reality, and climbs back on the painful round about of lies, deceit, theft, hurting others, fear of not being able to maintain his habit, of being caught, and persistent feelings of guilt. In case he decides not to go back to drugs, acute stress arising out of these two major feelings may even drive him to attempt suicide.

Helping the patients resolve guilt and shame

For long term recovery, it is very important that the patient takes remedial measures to resolve his feelings of guilt and shame. Maturity comes through facing those hurt feelings and working through them. All along, he has escaped from reality through the use of drugs and this has stunted his emotional growth. Recovery from addiction is an exploration; it is a process of discovering one's feelings, values, and beliefs. It is coming to accept and understand whatever he has done under the influence of chemicals in all its depth and intensity.

The Counsellor should make him understand that he just cannot change his past and he has to stop feeling guilty and ashamed about the many things over which he had absolutely no control. His 'If only' thinking ('If only I had been different..... If only I hadn't drunk so much.....', etc.) is non-productive.

The first step in resolving shame is in understanding his total powerlessness over alcohol/drugs and accepting himself with this 'limitation'. All along, he drank in an effort to escape from this reality - to try to become more relaxed, more capable, more 'whatever'. As a result of those efforts, he ended up just the opposite — got sick, passed out, and made a fool of himself.

"Why did I behave in such a shameful manner?"

The simple answer is

"You didn't want to, but you did!

You did because you are a chemical dependent. The answer to your 'why' is not in your will power or your strength or weakness, but in the fact that you have no power over drugs!"

Acceptance of the reality of powerlessness leads to forgiving oneself for shameful acts done under intoxication, and rectifying those by

feeling them to their depth. He may have to own up his secrets and talk about them. In doing so, he may discover that other people also have the very same or similar secrets. That is the only way to overcome the isolation and the self-hate that guilt and shame produce. The Counsellor should clarify that after admitting his past mistakes, he has to forgive himself and see to it that such acts are not repeated. He can thus draw comfort, strength and forgiveness from other people. Although fear and pride may discourage him from sharing his secrets, he should be made to recognise that as long as he holds on to his secret shame, he will continue to feel alone and miserable.

Also during recovery, he has to take responsibility to make amends for whatever he had done earlier. He can definitely resolve guilt if he starts making a list of the persons he had hurt, with an honest intention to make amends to them all. Making amends for the past behaviour starts with wholeheartedly apologising to those he had hurt. This is only the starting point. It however, calls for a total change in the attitude and behaviour of the chemical dependent. The recovering person has to take the responsibility of consistently keeping a caring, understanding and helping attitude towards those he had hurt. This is an on-going process which will help him 'let go' of his feelings of guilt and shame, and thereby enable him to feel worthy.

Forgiving himself, puts an end to the guilt and shame that perpetuate past attitudes, emotions and behaviour. Making amends to others signals the end of grief, his willingness to put the past behind him. Before he can accept the past and let it go, he should be able to forgive all past offences — his own and others'.

To sum up, recovery from addiction is a discovery of a feeling of wholeness. The chemical dependent can start resolving his guilt and shame during recovery by

★ understanding and accepting his powerlessness over addiction and over his past behaviour

★ wholeheartedly forgiving himself for his past actions and

★ making amends to those he had hurt

Additional information

A real life story

Let us listen to Vikram, a recovering alcoholic narrating his own life story.

"I was in my +2 when my father died. He was an honest worker in a press, and soon after his death I was offered a job in the same press on sympathetic grounds.

I had been drinking very heavily for the past five years. I used to come to the office drunk in the morning and there were several occasions when I had quarrelled with my co-workers and supervisors. Under the influence of alcohol, I had threatened my supervisor and one day shouted at my boss using indecent language. I had borrowed money from all my colleagues; and whenever they refused to lend money, I became spiteful. I was abusive.

My mother was struggling hard to run the family. She had chronic health problems; there was practically no support for her, I being her only son. Whenever she asked for money I used to shout at her and on several occasions even kicked her. I was violent and abusive. She was almost always in tears.

By now, my drinking had considerably increased. I tried several methods; but could not control the quantity, time or place of drinking. I was always thinking only of alcohol. My mother, my sister — no one had any meaning for me.

I feel terribly upset whenever I recall the 21st of October when my sister was about to be engaged. Even now I remember clearly how both my mother and sister pleaded, asking me not to drink just for that day. I shouted at my mother and went out. When I entered home, I was heavily drunk. The boy who was to propose to my sister, was already there with his parents. They saw me and were visibly shocked — their cold stares, their silent withdrawal from our house — nothing had any impact on me. What was remaining, was only the sight of my crying mother and sister which irritated me again.

The time came when I lost my job; was threatened by people who had given me loans. I was in a real financial crisis. I could not manage. Still I reassured myself that "the situation is not that bad", until one day I ended up in a treatment centre with pancreatitis brought on by heavy drinking.

I was afraid, guilt ridden, totally ashamed of myself when I shared my experiences at the treatment centre. I had to take extended treatment. I got myself admitted after a month in the After-care Centre and regularly started attending A.A meetings also. I felt terribly guilty over my unforgivable past actions; thoroughly ashamed of myself.

How am I going to make amends to those I have hurt?

How am I going to get out of my shame?

I have to — positively have to — make amends to them all.

I was told by my Counsellor that I will not be able to change whatever had happened in the past. Alcohol had taken absolute control, and I was not even aware of what I was doing. I need not continue to feel ashamed of the acts I had done under the influence of alcohol. Instead, I can plan my life from now onwards — plan for my present and work towards the future.

The A.A. members told me that I had to first forgive myself, accept myself, and improve myself. I took the next step. I immediately went to my mother, then to my sister, and whole heartedly apologised for whatever wrongs I had done. It was painful but I was determined to do it. They were so good that they accepted me for what I was. It did not end there. I decided that I had to support them, show care and understanding towards them till my last day. I started helping them in the household chores. I gave an advertisement in the paper, and looked out for a suitable alliance for my sister. I had to get her married. Yes! I had to see her enjoy life.

I met my supervisor, my boss, my co-workers — met each one in person and wholeheartedly apologised for my past

misbehaviour. I had got my Provident Fund money by then; so I was able to repay most of the debts I had incurred. After doing all these, I felt really light. I was confident I would be able to make amends to those whom I had hurt. It is one year since I stopped drinking. I have got a job, my sister is married to a gentleman in Bangalore; my mother's smile has come back and I am happy about myself.

On the day I completed my first year of sobriety, I arranged for a small get-together, invited all my previous co-workers, my mother, sister and all whom I had abused. After the tea party was over, I shared my feelings, genuinely feeling sorry for whatever I had done under the influence of alcohol. I reassured them that I was a totally changed man and will remain so.

I can now tell you with all conviction that negative feelings of guilt and shame have to be recognised and resolved. I was helped to recognise my own and benefit from it. My experience can positively help you recognise and resolve yours."

6

WORKING THROUGH GRIEF

Grief pervades the life of the chemical dependent. Unfortunately grief is rarely considered in most recovery programmes intended for the addict. Grief is a normal reaction to the total aspects of addiction and is therefore something that has to be understood and plans made for working to overcome it.

What exactly is grief?

Grief is a normal reaction to the loss of a cherished person or a thing. The loss can be

material — any object of value
physical — part or function of body
psychological — self-esteem/self-respect/self-confidence/reputation
significant person in one's life — through death or separation

If grief occurs due to any of these losses, the grieving person must be allowed to experience grief and helped through it with the most appropriate means available to him. Each society and culture has its own process of working through grief, and persons must be permitted to express their grief.

When Balan was 14, his father died. It was a rude shock to him, to his brothers, and above all, to his young mother.

His mother was terribly upset, shocked, afraid, totally shaken.

"This is not true. My husband cannot be dead.

No! this cannot happen to me."

She was filled with resentment; got angry; became thoroughly disappointed and disillusioned. Initially, she could not even accept the fact that her husband was no more — dead and gone for ever.

As this case study shows, grief passes through distinctly defined stages. The initial and immediate reaction is one of **shock and denial.** Events often seem unreal. At first there is a tendency to deny the loss.

"This can't be true. He is not dead. It can't happen to me."

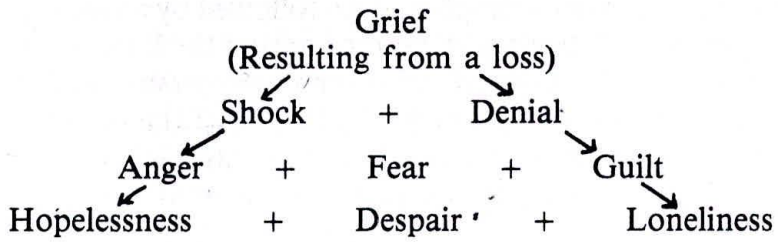
This is followed by anger and fear. The degree varies according to the loss and may not be apparent to others.

"I haven't done any harm to anybody. Why does God punish me like this? I am wronged."

Anger may be directed at anyone, whether he is a factor in the loss or not. Anger is often directed at oneself in the form of "If I had (or had not) done this or that, then the loss would not have occurred." This anger is often repressed and the "If" statements are often thought of, but not spoken. If this repression occurs, it leads to **guilt feelings.** The bereaved person suffers from a feeling of responsibility for the loss. This response is followed by a feeling of **hopelessness, despair** and utter **loneliness.**

"I can't cope. I have to suffer the pain all alone. My God! there is practically nobody for me! I wish I were dead!"

Emotional responses to any loss



Grief of the alcoholic*

Alcoholism has long been identified as a disease which results in numerous losses to the individual and to his family members. Alcoholics most often enter treatment in response to a loss or threat of a loss — threat of separation or divorce, loss of job, friends, financial security etc. The alcoholic who is actively drinking is involved in a perpetual

* The same applies to drug dependents also.

state of grief — a response to many losses that are experienced over the years of uncontrolled drinking. As the alcoholic progresses through treatment, he experiences yet another loss — **the loss of alcohol**, a major loss which needs to be grieved for. Total abstinence is the only solution to his sickness. He can never go back to social or controlled drinking. As a result, the grief he goes through will be no different from Balan's mother's condition. He is experiencing a deep personal loss — the **death of alcohol**.

For the past so many years, alcohol had always been his trusted friend. When he was unhappy or depressed, he drank and became happy. When he was disappointed and lonely, alcohol seemed to relieve him of his tension. To him, it was a trusted friend. It never let him down. The gratification it gave, had always been immediate. To put it plainly, he was tied to the bottle with an invisible chain. To him, it was all in all; nothing else in the world mattered to him — family relationship, job, finances, friends — everything receded to the background. He unconsciously erected a wall around himself — he and his bottle.

Such a person has to now give up alcohol totally; he has to permanently sever himself from his closest associate. The very thought will be frightening to him. He will be shocked, angry, resentful, guilt ridden, desperate and lonely. These phases of grief must be followed by a **realistic insight and reconstruction**. This consists in recognising the loss, accepting it, sharing the feelings involved with another person and making readjustments to carry on meaningfully inspite of the loss. He has to be helped to recognise and accept this loss, strengthen meaningful relations and seek new relationships to replace that which is lost.

It will be appropriate at this juncture to hear what Balan has got to say.

> *"When my mother was dazed, confused and grief stricken, a number of people came to console her — some were known, while a few others were just acquaintances.*
>
> *'It is just unbelievable. He was so young. How could this ever happen?'*
>
> *The same statements were repeated by each and every visitor. My mother cried and described the details to everyone — she*

was never tired of repeating the same again and again. She did not talk about anything else.

I noticed that many who came, shared their personal grief. There were young widows who had similar experiences. They talked as to how they were initially shocked and shaken and how they got back to living again without their partners. They actually spoke of methods they adopted in ***dealing with their loss.***

After 10 days of sharing and repeating, I saw a visible change in my mother. She could now accept the fact that my father was really dead and gone — that she could see or feel him no more. She also seemed to have gained some confidence in dealing with the loss."

The first step in overcoming grief is to share these losses with others who are understanding and can appreciate the intensity of grief. At this point in time, love, comfort and reassurance are needed — not advice. For an alcoholic, sharing with AA members and fellow sufferers helps a lot because they have also suffered the same loss.

The recovering alcoholic may experience feelings of depression and anger and may not even be able to relate these feelings to the loss of alcohol. It is important that the loss be identified so that he can begin the grief process. He may express his anger in self-destructive thoughts or actions. As he begins to face reality, overwhelming feelings of guilt will be experienced. Self-blame and guilt lead to frustration, which when internalised, will turn into depression. In the past, he would have dealt with these feelings by drinking alcohol, an option which is no longer available to him. Since new coping skills have not yet been developed, anxiety will result. He will lack direction and may not know which way to turn.

The recovering alcoholic may be reluctant to recall past drinking experiences, and will most often feel uncomfortable while abstaining. The resulting anxiety may be expressed or experienced in psychosomatic symptoms such as insomnia, irritability, agitation, nervousness or headaches.

John says, "At the treatment centre, when I attended lectures, when I talked to Counsellors and when I went to AA meetings, everyone was talking only about alcohol and the need to lead a life without it. All conversation centred on drinks. I got impatient. I shouted, 'You preach abstinence; ask us to forget alcohol; but at the same time, you talk only about drinking and keep constantly reminding us of alcohol. Don't you have anything else to tell us?'

Albert, another recovering alcoholic, patted me on my shoulder and calmly explained to me, 'Now it is very important to talk about alcohol, about the problems associated with drinking, about leading a life without alcohol etc. This is the only way of getting rid of fear and sorrow. This is the most crucial turning point in our life. You keep sharing your sorrow and grief with us because we have also suffered the same loss.' "

Sharing with AA members and Counsellors is the only way of **accepting grief, confirming it, and learning to lead a meaningful life without it.** He will slowly begin to understand his realistic equation with alcohol — that it can no more give him pleasure; drinking will lead to pain and only pain from now on.

This reminds us again of Balan's reaction.

"Even today I remember, that on the 13th day of my father's death, new dresses were bought, a feast was arranged and a visit to the temple was planned. I resented this custom. I honestly felt that people were celebrating my father's death.

My mother told me, 'There is nothing wrong in wearing new clothes; eating a good meal or going to the temple today. This social sanction is given only with a purpose. After all, father is dead and is not going to come back to us. It is our misfortune. In spite of this, our life has to go on. This ceremony signifies the need for leading a productive and meaningful life even in his permanent absence. We have cried enough, and there is no point in clinging on to sorrow. At some point in time, we have to start doing our duties and begin to live again.' "

Sharing helps the alcoholic slowly realise that there is no point in permanently lamenting about something which cannot be changed — his powerlessness over alcohol. Talking about his grief and about the feelings associated with it, gives him relief. The solution to the pain is in recognising it, owning it, feeling it to its fullest and laying it to rest by sharing.

If one goes through each phase of grief and completes the process, he will be able to go on with his life. If, on the other hand, he skips one or more of the phases, he will suffer from unresolved grief and will later have to come back and complete the grief process. If he does not, the future loss will bring with it not only that loss, but also all the unresolved feelings resulting from the former loss. This will inevitably lead him back to drinking.

What are the other losses suffered by the alcoholic?

He suffers from the loss of the bottle; loss of drinking friends; loss of a routine involved in drinking; loss of self-esteem; loss of self-confidence; loss of respect from family members and loss of personal dignity. These losses are also subject to the grief process and therefore must be dealt with.

How can his grief be resolved?

As the alcoholic starts accepting the loss and begins to cope with the resulting stress, **resolution of the loss** can be achieved. New coping skills must be learnt and developed. As the individual's self-esteem begins to increase, as anger and depression decrease, internal resources can be built.

A structured practical plan alone can help the alcoholic to become balanced and happy - happy that it is possible for him to lead a comfortable life without drinking.

★ Working through grief provides a chance to say goodbye to the old memories and the old drinking friends and an opportunity to bring new people close together in a mutually supportive environment. These new relationships can be developed with persons who are

recovering from alcoholism, and it will be very helpful for him to attend AA meetings and other therapeutic groups. New relationships should be developed only with persons who will have a positive impact on the recovering person's abstinence from alcohol.

★ Readjustment starts with getting a job. Applying his mind to the work will make it interesting and productive.

★ He should strengthen his family relationship by spending time with his wife and communicating with his children.

★ He should find out new recreational activities and resort to new ways of having fun. If he has any idle time, he can spend it in pursuing old hobbies.

★ The foundation to recovery is in the realisation of his total powerlessness and surrendering to a Higher Power which alone will give him lot of mental strength to lead the new life.

Role of the counsellor in 'Grief work'

It is necessary for the Counsellor to be patient and supportive. He should recognise and respect the feelings of each person. The Counsellor should avoid statements like,

> *"You have had enough of problems. Even after that it is strange you haven't learnt a lesson."*

These reactions inhibit grief.

The Counsellor should also avoid becoming defensive if, by chance, the alcoholic's anger is directed towards him.

The recovering alcoholic may need help in identifying the loss and in verbalising what the loss means to him. The Counsellor should allow the individual to approach this in his own time schedule. It is important that the Counsellor should on no account attempt to accelerate the grief process.

For the alcoholic, losses will be cumulative. Past losses like loss of job, loss of finances, loss of relationships etc. would not have been resolved. These losses will now return to the individual's awareness. As the person has been unsuccessful in resolving losses, he is not likely to deal with present losses and resolve them without proper support and assistance.

Apart from these, some deaths might have even occurred in the family during the alcoholic's drinking days. The alcoholic would not have mourned; instead he would have escaped the pain by using chemicals to numb himself. During recovery, however, he may deeply regret and feel guilty. This grief which is not resolved, does not go away. It should be put to rest through a process of re-experiencing earlier losses so that they become real. The Counsellor should allow him to talk over the pain so that these long-repressed, long-denied feelings come into his consciousness once again. He may open up wells of hidden anger along with his disappointments and deprivations. Fear, guilt and anxiety may also surface when he begins to talk about the past. However painful, he should be allowed to ventilate his feelings, because mourning is necessary for his personal recovery.

The grieving person also needs to have his feelings validated — to know that they are real, normal and expected. He should be encouraged to explore his feelings and assisted, if necessary, in assigning them meaning. He may need help in acknowledging the loss and exploring feelings in relation to the loss. Therefore the loss should be identified, examined, and its significance defined.

In short, in a supportive environment, the Counsellor should allow the alcoholic to ventilate his fears and feelings that accompany his loss. He should be allowed to acknowledge his pain and ultimately release it. Unless he admits his anger, bitterness, depression, self-pity and loneliness, he will never be able to let them go. And these buried feelings can consume him, making it impossible for him to move beyond these losses towards recovery.

Sharing his feelings in group therapy and individual counselling sessions leads him to slowly accept the loss and plan a new life style, structuring his day-to-day activities. This, along with recreation and prayer, will help him in successfully dealing with his loss.

Within the family system, healing is as contagious as sickness. When one member of the family seeks help and overcomes grief and remains in that condition of healing without changing back to the old methods of dealing with problems, it is highly possible that others in the family also move towards recovery. Everyone has a choice to overcome grief with the help of those who bear the scars of the same wound.

Once a person recognises grief and begins to talk about it and the feelings involved with another person, he will begin to find relief from the pain. Any attempt to cover these feelings with alcohol or other chemicals will not meet with success. He has to deal with grief through the definite phases, make readjustments by effecting qualitative changes in his life-style, and only then can his life go on unencumbered.

Additional information

Following is a record of several stages of grief as explained by researchers over the years. This may be used as a reference by the Counsellor.

The Stages of Grief

Lindemann, 1944

1. shock and disbelief
2. developing awareness
3. resolving the loss

Bowlby, 1961

1. weeping and anger
2. disorganisation
3. reorganisation

Westberg, 1962

1. shock
2. emotional release
3. depressed and lonely
4. physical symptoms of distress
5. panic
6. guilt
7. anger and resentment
8. resist returning
9. hope
10. affirm reality

Engle, 1962

1. apprehending the loss
2. attempting to deal with the loss
3. final restitution and resolution of the loss

Engle, 1964

1. shock and disbelief
2. developing awareness
3. restitution
4. resolution

Kubler-Ross, 1969

1. denial and isolation
2. anger
3. bargaining
4. depression
5. acceptance

Parkes, 1972

1. numbness
2. pining
3. depression
4. recovery

Kavanaugh, 1972

1. shock
2. disorganisation
3. volatile emotions
4. guilt
5. loss and loneliness
6. relief
7. re-establishment

Colgrove, 1976

1. shock and denial
2. anger and depression
3. understanding and acceptance

Baker and Kelly, 1978 Tasks related to loss

1. surviving
2. healing
3. growth

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7

HEALING THE HURTS

A chemical dependent harbours lots of frustrations, resentments and hurt feelings. During the process of his dependency, he would have hurt a lot of people. They, in turn, would have hurt him back. In order to escape from these hurt feelings, previously he would have abused chemicals. Now during recovery, these accumulated unresolved hurts lead to stress, negative feelings and growing problems. Added to that, during recovery, he may be experiencing fresh wounds of hurt. Emotional pain can be very deep and destructive. If hurts are not resolved, they can interfere with relationships and also hinder the recovery process.

How do hurts happen?
Can they be avoided?

Relationships are a source of strong feelings — both positive and negative. Happy and hurtful moments come from them. The closer the relationship, the stronger the feelings it gives rise to. Hurts and disappointments are as deep or as slight as the person's involvement in the relationship. Following are a few reasons why hurts happen.

When the chemical dependent's views are not regarded/respected

Family members and significant others frequently act or speak in ways that are very different from the way the recovering person would like them to. Even when he is abstaining, they may not always function in accordance with his expectations. He often interprets their disagreement with his views as a rejection of himself, and their actions are therefore seen as deliberate moves to hurt him.

Arvind was a brown sugar addict who went home on an outpass when he was at the After-care Centre. On that particular day, a few of his relatives visited his house. Arvind's mother immediately called him aside and said that he need not see the visitors or talk to them.

Arvind was deeply hurt because he thought that his mother was ashamed of him, and that was the reason why she had sent him upstairs.

The ***fact*** *was Arvind's mother thought that it was too early to expose him to the relatives. She felt he was not as yet open about his problems, and she really wanted to give him some more time to settle down. She had a lot of care and concern for Arvind and that was the reason why she asked him not to see them.*

But Arvind's ***opinion*** *was that his mother thought that he was not worthy enough and that she was too ashamed of him.*

Arvind had loaded the situation with his negative interpretation and turned it into a cause for hurt.

If the chemical dependent refrains from adding his judgement to others' behaviour, he will be able to see their point of view better. Then it will become easier for Arvind to see his mother's act as a sign of love and warmth rather than as a mark of shame and hatred.

In short,

★ When situations are interpreted to form generalised opinions, hurt is created.

★ Objectively viewing and stating the facts of the situation, aids understanding.

When the patient's legitimate needs are not taken care of

When others fail to meet his needs, the chemical dependent feels thoroughly disappointed. He immediately comes to the conclusion that they do not care.

During recovery, Mohan felt that his wife did not have any regard for him. He had the following complaints about her.

- *She does not iron his clothes properly.*
- *Does not take pains to make good food for him.*
- *Did not visit his parents or provide moral support to them.*

Mohan was upset and deeply hurt; but he never expressed his feelings.

Mohan shared his problems with one of his peers at the After-care Centre. His friend suggested that he openly tell his wife whatever he expected of her. Mohan was initially reluctant. His friend insisted that he should give it a try.

With a lot of hesitation, Mohan told his wife that he would like to look clean and her ironing his shirt would be very helpful. He told her how hungry he felt and how he longed for good food. He also conveyed to her that he was worried about his father's health and that he would be very happy if she took care of his parents. To his surprise, she was very receptive, and from then on, their relationship changed for the better.

When hurt sets in, "Why?", "How could she?" and similar self- pitying responses crowd the mind. These do not lead to the resolution of the problem, but only keep the person running in circles.

Asking himself "What do I do now?" rather than "Why did this happen to me?", will take him closer towards solving the problem. Meaningful relationships call for openness from both sides. Unexpressed needs run the risk of remaining unfulfilled, giving scope for hurt.

Therefore, it is necessary that

★ The person explicitly states what he wants the other person to do.

★ Being able to express needs, brings people closer and strengthens relationships.

When negative criticisms flow freely

When negative feedback far exceeds positive feedback, the person feels rejected by the other. If this painful feeling is not handled, it weakens his self-esteem.

Vikram felt his mother was being very difficult. Her choice of words, her suspicious nature, her constant comparison with his friends, her talking about his past behaviour in front of his brothers — everything hurt him. Vikram was upset and angry. This led to further problems and a vicious cycle was in progress.

After talking to the Counsellors and his peers at the After-care Centre, slowly Vikram learnt to cope. How did he manage that? What brought about the change in him?

They actually made him look at the problem from his mother's angle. They made him see the fact that his mother had arranged for his treatment thrice during the past two years. She had not hesitated to spend money, and in spite of her health problems always made it a point to visit the hospital everyday. In spite of her repeated efforts, Vikram's problems did not seem to have totally disappeared, and that was probably the reason behind her frustration.

Vikram could see his mother's plight and thought to himself that he would try not to get provoked by his mother's words from then onwards.

If he had really put this thought into practice, it would not only contribute to his peace of mind but also help him in improving his relationship with his mother.

In short,

★ Understanding the problem from the other person's position helps in resolving hurt feelings.

When the recovering person lets trivial instances provoke him

Misery loves company. When hurt, the person starts looking out for further hurts to add to his collection. He waits for one wrong move from the other person, quickly converts it into a hurt and adds it to his collection of hurts.

Mithun was upset again with his wife. He was very angry with her and reflected on her words that hurt him the previous week.

On Monday, when he was leaving for the office, she said, "Come back early today."

(She is waiting to find fault. She thinks I may go out and drink.)

When he brought his salary home, she asked, "Got only so much of money this month?"

(What does she mean by this? Does she think I have kept some money in reserve for drinks?)

Why is it that any remark from his wife upsets Mithun? Possibly because he is already experiencing stress arising out of physical discomfort he is putting up with during abstinence.

This stress makes him uncomfortable and he exaggerates every remark and converts it into a cause for hurt.

Mithun would not have been hurt if he had paused for a moment and recollected all the positive qualities of his wife. He could recall instances when she had made so many sacrifices, had taken so much of his burden and had been so very patient. These thoughts would have definitely changed his entire perception.

When hurt feelings are not properly handled, they weaken the relationship. Piling up hurts destroys fine relationships. Weeds, if left unchecked, can ruin the most beautiful garden. Hurt grows bigger and bigger, making healing more and more difficult and complicated.

So,

★ Even minor issues are likely to upset the person when he is handling stressful situations.

★ When hurt, the chemical dependent should recollect all the positive qualities of the person and not harp on just one discordant remark of the present.

When the person keeps decade old hurts alive

Many chemical dependents carry a huge load of hurts of the distant past. Pulled down by the sheer weight of negative feelings, they cannot relate to the present. They willingly lie chained and stay stuck to the past.

Sanjeev had been carrying a lot of hurt feelings arising out of his wife's behaviour in the past. She had been staying with her father when he was drinking heavily and she was unable to cope. But when he decided to take treatment, she came back to him and extended lot of support and was really helping him in his recovery.

Sanjeev never appreciated her help, but was always clinging to his past resentments. He could not forgive her because

- *she left him and went away.*
- *his father-in-law made an adverse comment about his behaviour in the presence of his friends.*
- *she refused to borrow money from her Provident Fund to pay back his debts.*

Carrying the hurt, and keeping painful memories alive, the person reacts only from that level and reacts negatively. The reasons for their long-standing hurts are unchangeable. They no more have any relevance. Still, they give so much of their present life to nurse the hurt and keep the past alive. When a person is not willing to 'let go', the hurt grows and eats up more and more relationships, leaving him distraught and lonely.

Therefore,

★ Old hurts keep the person chained to the past and come in the way of other relationships too.

★ "Letting go" has to be done — not for the sake of others, but for themselves.

Blocks which prevent hurt feelings from getting resolved

What are the usual thinking patterns which prevent the chemical dependent from resolving his hurt feelings?

He usually waits for the other person to take the initiative. Normally the chemical dependent's arguments will be

- "After all I have given up drugs; let her start showing love and affection."
- "She knows just as well as I do. After all these are issues which affect both of us; let her change first."
- "I have sacrificed; have done so much for them; let them make the first move."

Sometimes, the recovering person believes that just ignoring hurts, will work. But, this is not true. In close relationships, ignoring hurts and pretending that nothing is amiss, is like a volcano waiting to erupt. Hurts add on quickly and turn trivial instances into major issues. Even in formal relationships, time heals only if the person allows it to.

The therapist should make the recovering person understand that he is not losing or giving in when he takes the first step to resolve his hurt. On the other hand, by doing so, he is only proving that he cares more.

When he hits out at other people with words, they will do the same with ease. Instead, if he stops and says, "Come on! let us do something and work on our relationship!", they will find it difficult to turn him away.

Hurts can be healed

Given below are some techniques and tools. These are based on authentic experiences of recovering people. They do work. Among these, the chemical dependent can try one or two ideas or techniques which he feels may be useful and relevant. He is sure to be immensely benefited. However, the Counsellor should appreciate the fact that healing of hurts takes time since they have got accumulated over a period of time. He should never try to accelerate the process; instead he should let the patient take his own time to resolve them.

Tools to heal hurts

★ The chemical dependent may be asked to maintain a diary of his feelings. At the end of the week, say, on a Sunday, he can record two instances when he felt good about himself.

It can be

- somebody at the After-care Centre expressing his gratitude for the timely support.
- the peers' comment that he was very neat and clean.
- the Counsellor appreciating his 'honest sharing'.

He can record one instance when he felt hurt or unhappy. It may be

- a remark from the Counsellor for being late.
- wife going to her mother's house without informing.

Over a period of time, the recovering person will get to see so many positive things in his life, and also the common triggers that cause hurt, and he will probably find his own unique ways of dealing with them.

★ If one issue is repeatedly giving rise to hurts, he should be encouraged to list the options he has. With each option, he should record the result he anticipates.

To give an example,

When Jayakar was recovering, his wife always talked about how shameful his behaviour was, how many times he broke promises, the amount of opportunities he missed, the way he carried on in an irresponsible manner — all during his drinking days. Jayakar got annoyed; but tried to put up with it patiently. He found it very difficult. So he decided to resolve the matter.

What did he do?

Jayakar listed the options and the possible outcomes.

Options	**Outcomes**
Leave the place without making any comment.	May be able to cope for some more time; but definitely not permanently.
Shout at her and release angry feelings.	Wife may resent and shout back. Relationship will become more strained.
Order wife not to speak in that manner.	She may not listen and this will show on their relationship.
Discuss issue openly focusing on how he is affected and how intensely he feels about it.	She may argue and and try to justify or she may agree to stop talking about the past or some solution can be identified.

Jayakar decided to try the last option which seemed the least hurtful and the most likely to succeed.

Studying options, clarifies the recovering person's thoughts and needs. By carefully considering his course of action, he will act constructively rather than react impulsively.

★ When the hurt is threatening to break a long standing relationship, the chemical dependent may be asked to list two qualities that he likes in the other person.

It may be his wife

- taking lot of interest in cooking and serving good food.
- helping children in their studies and giving them emotional support.
- always looking neat and clean.

★ Write two situations in which the other person had been supportive. It can be

- managing the house efficiently when he was financially broke.
- taking care of his father when he was hospitalised.

This helps the chemical dependent to see the other person with understanding and gives him assurance that with so many strong points supporting her, he can rebuild the relationship.

★ Strong relationships mean better communication and less hurt. To facilitate this in the family, the chemical dependent may be educated to do the following, whenever there is an opportunity.

- Encourage each member to appreciate some nice deed or act of one other member.
- Help each member talk about his or her personal achievements in the recent past.

They can do such things in an informal, natural manner, say, over dinner, or while eating out. Being able both to give and receive positive strokes, leads to a strong self-esteem. A strong self-esteem helps in handling hurts easily.

Recovery from chemical dependency will be secure only if relationships are strong. For any relationship to be strong, hurt feelings have to be resolved. Therefore, whenever hurt, the chemical dependent should

★ ask himself — "Why am I feeling hurt?"
★ check his options — "What can I do about it now?"
★ initiate action based on the analysis.

8

ANGER MANAGEMENT

Anger is a normal human emotion. Still, chemical dependents have special problems with anger. In their families, anger is often expressed in extreme ways through emotional abuse and neglect, violence, sexual abuse or through abandonment. When they express anger, they may be overwhelmed by feelings of guilt. Fear, anger, guilt — for them these emotions are all tied together in a negative way.

They try to ignore their angry feelings, hoping that these will go away on their own. But they don't. They usually get worse. Then they feel guilty and end up abusing chemicals once again and behaving in ways that can hurt them as also the people around.

This is a chapter on anger, specifically about how it hinders the process of recovery from chemical dependency. Abstinence does not make anger disappear. The fact is sometimes abstinence does make anger worse, both for the dependent and his family. For instance, when the alcoholic is drinking, the family members have something to blame his anger on — the bottle; the booze; the drunkenness. During abstinence, the bottle is taken away and what is left is just the anger with nothing to blame it on. They end up confused.

Anger is an emotion that lasts long after the chemical abuse has stopped. Even after abstinence is achieved, aggression may continue unless the chemical dependent learns to channelise aggressive feelings in less dangerous ways. He becomes angrier when under pressure. Learning to ventilate anger in a positive manner is an important part of the recovery process.

Unresolved anger, whether it is openly discussed or not, can hinder the recovery process. When anger is loud, explosive and frightening, it can be recognised. We can see it, hear it, and feel it. But there is another kind of anger — controlled, quiet, ice-cold. It can take many forms —

depression, manipulation, suicide and so on. These varied responses can mask what is really going on under the surface — unrecognised rage. They may not yell or scream or kick at each other, but the anger is there in the clenched jaws, the cold stares, the slammed doors and the subtle threats. This kind of anger often builds in families where a chemical dependent is abstinent, but neither the patient nor his family is working on the recovery process. Abstinence by itself is no guarantee for happiness. For a chemical dependent, it is the starting point, the single most important thing necessary to begin the **process** of recovery. And this process calls for committed work.

For positive recovery to take place, anger needs to be acknowledged, dealt with and resolved. The recovering person has to be made aware that there are healthy ways to express anger and that the management of anger can contribute a great deal in the process of recovery, making it less stressful and reducing the chance of a relapse.

Indirect expressions of anger

Anger can manifest itself in disguised ways, unrecognised both by the angry person and his target.

Mahesh says, "After treatment, I had been totally staying away from alcohol. I went back to my office, from where I had received a suspension order before I took treatment. I was filled with hopes that they would take me back immediately. This did not happen. They made me come the next day....the next week.....and so on. After about a month, they bluntly told me that they could not take me back. Why did they make me run from pillar to post? Could they not have said this earlier?

I was thoroughly disgusted and heart broken! I was totally disappointed!....Upset!

I told my friend, Peter, 'I am so depressed that I wish I were dead! I feel like committing suicide!'

Peter immediately asked me, 'Are you angry?'

I said, 'No, I am only depressed.'

He replied, 'You feel hopeless; you are convinced nothing is going right for you; future looks bleak and you are not enjoying anything — look at yourself and see if you are angry about something.'

He was right; I was angry at my own self."

Many chemical dependents learn to be passive and silent, while underneath, they seethe. Even when they are shouted at, they may not open their mouth or react.

Ramu says, "Whenever my wife shouted, I kept quiet; I had learnt to control and stifle my temper and sit on it. But inside I would be boiling. I couldn't admit I was angry — not even to myself. I was well brought up, which meant I had to pretend — I had to act."

When Ramu swallows his anger, pretending it does not exist, he is sure to explode, over reacting to any minor irritant. When pushed down and hidden, anger can be like slow acting acid splashed on one's self-esteem. It gnaws, eats, burns, corrodes, until nothing is left but a raw edged hole, an empty pit of despair. Sometimes, suicide may look like the only way out. Ramu may start craving for a drink again. For him, anger management should be an essential part of his recovery plan.

Sarcasm and biting humour are also displays of anger.

"One day I came home early to take my wife out for a movie. It was already late and she was not yet ready. I smiled and said, 'How smart you are! You are always ready on time!'"

Even though he was smiling, he was actually boiling with resentment and anger.

Those who suffer from chemical dependency have another major problem that does not always look like it is related to anger, but it is. It is **self-pity**, caused by negative self thought. They feel so sorry for themselves, because their family, friends, co-workers, the whole world does not give them what they want, need, and feel they deserve. They wallow in self-pity and seldom stop to consider whether what they want from their family and friends is reasonable. They make unreasonable demands and are angry when they are not met.

To complicate things, some of their demands are not even voiced. They just expect other people to know what they want. They are angry that life is not fair, that it is full of hardship and disappointment. They often think of themselves as victims tossed around by an uncaring world. They strongly believe in luck — always bad luck for them and good luck for everyone else. Whom do they blame? — anyone who is handy — wife, children, subordinates etc.

A disturbing manifestation of hidden anger is the reaction of body to it. Unrecognised anger can contribute to many physical disabilities like migraine head ache, pain in the neck, sleeplessness, nervousness, heaviness in body etc. Anger is a form of energy, which, if repressed, must come out somewhere and it can harm almost any part of the body or influence the emotions in a negative manner.

One outlet of repressed anger is accidents.

> *"When I am angry, I slam the door; get into my car and continuously blow the horn. I drive so fast that I often run into some accident. One day, when I was watching a tennis match on the TV, my wife insisted on my hanging a picture on the wall right away. I was so angry that I hit my fingers with the hammer. I must have been angry earlier, but did not realise it."*

So far, we have seen that anger may be disguised in many ways, some easy to recognise, some not. It may appear in language, action or body reaction. One may get aches and pains; injure himself or others; become withdrawn or depressed.

Hidden anger

Feelings	Expressions
Disappointment	"I am upset ..... I am heart broken."
Depression	"I feel like killing myself" "I wish I were dead."
Silent Resentment	(Quiet)
Sarcasm	"Ah! very smart!" (meaning the opposite)
Self-pity	"Poor me!" "Only I suffer."

Outcome

Physical signs	Psychological signs	Behavioural signs
Headache	Loneliness	Verbal abuse
Stiffness	Depression	Violence
Lack of appetite		Unnecessary arguments
Sleep disorder		Isolation from Society
Being tense all the time		Silent brooding
		Return to drug/alcohol use

Why do chemical dependents get so angry?

There are two main reasons for quick, open expressions of anger. The first is they have accumulated so much anger in them, that it requires only the slightest provocation to set them off. During abstinence, they want a quick change in the attitude of all others around. But to their disappointment, there is always tension in the air, mixed with the memories of yesterday's pain. When the chemical dependent sobers up, initially there is not much of a change in the family dynamics. Anxiety, tension and mistrust lurk constantly in the air, even on problem-free days. Everyone recalls with burning resentment every injustice, every offence, every wrong committed. The memory is embedded deep and it festers. During recovery, the chemical dependents are also hiding wounds that have not been allowed to heal — **resentment wounds** — the gashes, the trauma and lacerations of bitter anger. The resentments can very often affect their jobs, marriages and friendships; and, ofcourse, their recovery.

The second reason is that, over a period of time, they had found that anger works, and they are therefore conditioned to continue its use. Since people dislike and fear displays of temper, they give in to the angry person. Thus, for them, anger becomes a pattern of behaviour.

What happens as a result of the chemical dependent's anger?

Anger is a strong impediment to recovery and if left unchecked, their chemical abuse will creep in. They try to balance their emotions like a child. The child cries. They do not cry, but go back to chemical abuse. If something does not happen the way they want, the time scale in which they want it to happen, they become impatient. They cannot wait. They want to seek immediate gratification and therefore get back to drinking/drug abuse.

For positive recovery to take place, anger needs to be acknowledged, dealt with and resolved. However, the Counsellor should make the patient understand that there is no 'quick fix' for this problem; no simple solutions and no set formula to deal with this complex issue. However, there are a few steps, which, if followed, may lead to a reasonable solution.

A few steps in dealing with anger

Learning to deal with anger and resentments, learning to forgive people, and learning to forgive themselves for the wrongs they have committed are the most important elements of their recovery.

The first step for the chemical dependent in dealing with anger, is to **recognise** that he is angry and **admit** it to himself. Anger, of which one is aware, is much less harmful than unrecognised anger. If the person is tense and does not know why, or has any of its disguised manifestations, he should be allowed to explore the possibility that he is angry and not aware of it. If he feels depressed, he should introspect and find out the reason for his anger. If he is feeling sad, fed-up, hurt, frustrated or disappointed, the question he has to ask himself is, "Am I angry with myself? Am I afraid of facing the situation?" Anger may not always be reasonable; but that does not mean it does not exist. Anger is an emotional response, and can be dealt with only if he is aware of it as an emotion.

The next step is to **identify the source of anger.** Once he has recognised that he is angry, he has taken the most difficult step. Then the problem

is to understand where his anger is coming from. It may be very obvious or very subtle.

He may be frustrated as a result of his inability to pay off his debts. His body may be aching and paining. Since it is not possible for him to shout at anybody else, he may show his anger on his wife. A few minutes' delay on her part in bringing coffee, is reason enough for him to blow up. When he reasons this out, he will understand that his anger is out of proportion to the cause. It is **misplaced anger** — an outlet for anger generated by someone or something else. The chemical dependent should be made to understand that if anger is repeatedly misplaced, meaningful relationships are likely to become sour.

The next step is to **determine whether anger is realistic or not.** If he has recognised that he is angry, and identified the source of anger, he should proceed to find out whether it is realistic or not.

Gopal narrates,

"When I came from the office, I found that my wife had not ironed my shirts. I was terribly upset because I was leaving for Bombay the next morning. She had not packed my things....., not even kept them ready. I shouted at her.

'You were so busy that you didn't find time to keep my things ready....Is it?'

She shouted back, 'Do you expect me to read your mind? You never told me you were leaving for Bombay tomorrow. You don't say things properly....., you know only to shout at me!'

This shouting continued and in my rage, I went away without eating.

I thought for sometime and finally realised that my anger was not realistic. I had not told her that I was leaving station the next day, and that I wanted her to pack my things. My expectations were not expressed, and therefore I had no reason to feel upset. It was not fair on my part to expect something when the other person was not aware of my needs."

When the fact that he is angry, the source, and the reason have all been brought into the open, the question is how to **deal with it realistically.**

In a chemical dependent's home, there is a set pattern in which anger shows itself. The patient is extremely angry and shouts throughout the night. His wife shouts the next morning. In either case, the other person does not listen at all. Neither of them feels guilty for having shouted. As each one shouts in turn, their anger gets 'evened out'.

The first step the chemical dependent has to take, is to break this 'evened out' cycle. He has to stop reacting immediately. Instead of shouting in rage, he should try other methods, to break down anger. After this, he will be in a proper frame of mind to communicate or talk about his feelings.

Sunil underwent treatment for his alcoholism. After a month's abstinence, he went back to his office. He was expecting a promotion. To his utter disappointment, he learnt that many others had got their promotion whereas he did not get one. He was sulking in the office and as soon as he entered home, he shouted at his wife complaining that tea was very cold. He had a headache, pain in the neck and was feeling depressed. He was raising his voice and arguing unnecessarily. Suddenly it occurred to him that he could try 'Anger Management' methods which he learnt at the After-care centre. The following steps which he adopted, helped him to understand, recognise and deal with anger in constructive ways.

What did he do?

He recognised his angry feelings

How did his anger show up? Physical signs included headache and pain in the neck. Psychological signs showed themselves in his feeling of depression. Behavioural sign was his unnecessary arguments. Now he realised that he was angry and admitted it to himself.

He identified the cause of his anger

What was the situation which triggered his anger?
He expected a promotion, but he did not get it. So he was angry with his boss.

Was his anger misplaced or properly placed?

It was quite obvious that his anger was misplaced. He was unable to shout at his boss; therefore, he shouted at his wife.

Was his anger realistic?

To him, it seemed realistic, because he felt he deserved a promotion.

He decided to deal with his anger realistically.

What did he do?

He fixed up an appointment with his boss, the next day. An open discussion revealed that his boss' expectations were different. He noted down whatever the boss said was a pre-requisite for the promotion; and after he came home, he chalked out a practical plan. His action plan included:

- ★ *The amount of work he had to put in for the next six months.*
- ★ *Ways in which he had to develop his professional skills.*
- ★ *Plans he had to make to manage his time.*

Once he jotted down everything in detail, he felt he would be able to get his promotion in the course of the next few months. Surprisingly, he found that he was not half as angry as he was a few hours before.

What is it he can do before shouting in rage?

Anger produces a lot of **energy**. This force can be used constructively. **Physical activity** is a healthy outlet for getting rid of anger. Active sports, gardening or cleaning the house are alternatives for the release of pent up energy. May be, he can go out for a small walk in the open.

Now he will be in a position to communicate. Improving the **communication** with family members helps in better understanding of one another in the family, thus giving no scope for misplaced or unrealistic anger. It is important for the couple to discuss their feelings in an effort to arrive at a reasonable solution. If the husband or wife has been accumulating anger without recognising it, this anger can interfere with their communication and make it extremely difficult to understand the real problem.

Given below are certain tips which can be followed by the chemical dependent while making or receiving a complaint. The Counsellor can

educate him as to how these can be effective. To make it convenient to use, the presentation is in direct narrative - as though the Counsellor is directly talking to the recovering person.

While making a complaint

- Talk directly to the person who has hurt you. **Direct eye contact is a must.**
- Talk to the person when he is alone.
- Make your complaint as early as possible. Never try to postpone.
- Do not minimise or exaggerate the problem. Be descriptive and not judgemental.
- Under no circumstance should you compare.
- Avoid using words like 'always' or 'never'. This will dilute the seriousness of the problem.
- Make only one complaint at a time.
- Do not sound apologetic. Do not use any preface to justify your stand.
- Do not repeat a point once you have made it and the other person has understood it.
- Compliment the person if you have anything to appreciate in him. This will enable him to remain open to your criticism. Appreciation and criticism should always be in the proportion of atleast 2:1.

To give an example,

Ram was very hungry when he came home and expected a good meal. To his utter disappointment, when he sat down to eat, he found that food was not well prepared. He felt upset and wanted to convey his feelings to his wife. He communicated properly, and at the end, his wife, Latha felt sorry for the bad job done. Let us now see how Ram conveyed his feelings effectively; let us also know how ineffective he would have been if he had conveyed it the wrong way.

Right way	Wrong way
"I am very disappointed... I was eagerly looking forward to a sumptuous meal."	"You were so busy that you didn't have the time to cook well, is it?"
"Today curry is burnt; and sambar is salty."	"I have dined so many times at Rajesh's house. You should learn from his wife. How well she cooks!"

While receiving a complaint

- Make eye contact when you are being criticised.
- Listen carefully without interrupting at any point. Your motto should be **'Listen, Listen, Listen.'**
- Do not find fault with the person who is criticising you.
- Do not rationalise or make use of your intelligence to cover up your mistake.
- Communicate to the other person that you have understood his point.

If anger is not recognised and ventilated properly, it will accumulate in the same manner as pressure gets collected in the pressure cooker. The safety valve prevents the cooker from bursting by releasing excess pressure. **Relaxation** will prove to be a good safety valve for the angry person. The chemical dependent has to find out what gives him peace and balance, and resort to that activity every day atleast for some time. This will prove to be an effective measure in releasing anger positively.

Anger which is a strong impediment to recovery, can be successfully channelised, if only the chemical dependent can be trained to identify the cause of anger and see whether it is justified or not. Pent up anger can be easily diffused by taking up constructive physical activities, relaxation methods and open communication. The Counsellor can reassure him that proper recognition, understanding, and channelising of this emotion can change his entire way of life, making it more productive, more comfortable and more balanced.

Additional information

Violence and chemical dependency

A certain percentage of chemical dependents are often the initiators of violence within the family. Domestic violence is a crime that is committed behind closed doors in the privacy of the family. It is a problem that tends to be denied, tolerated or ignored by our society which has always viewed abuse within the family as a private matter rather than as a social problem. An effective method for handling the issue of domestic violence is necessary. The guidelines given below have been designed to help Counsellors in chemical dependency settings deal more effectively with the problem of violence within the family.

Characteristics of abusive men

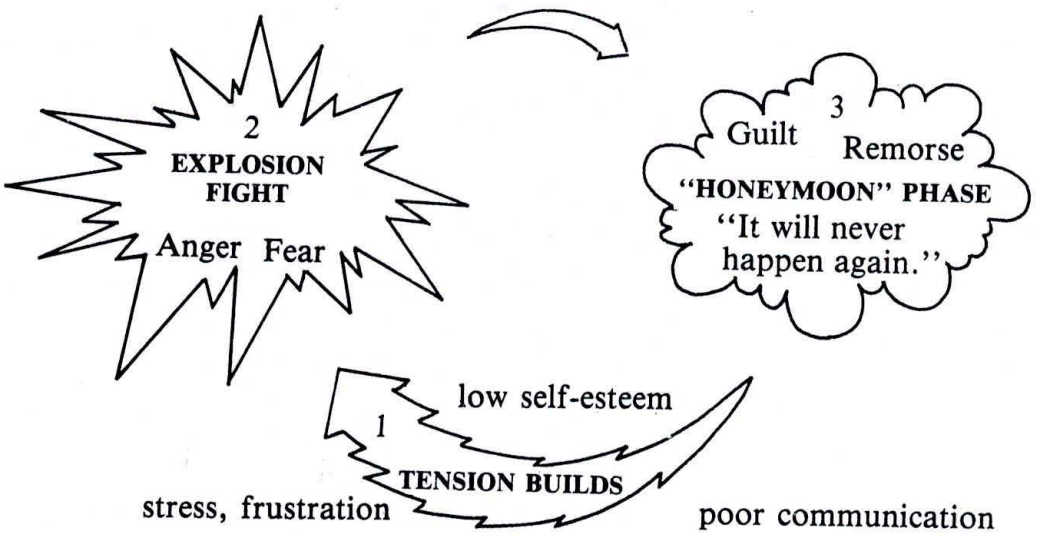
- Belief that men have more rights than women
- Low self-esteem. Afraid of losing the woman.
- Fearful of losing control. Possessive/jealous.
- Difficulty in identifying and expressing any feeling other than anger.
- Total dependency on the woman. Few other support systems.
- Poor stress management and conflict resolution skills.
- Threat of suicide or homicide if woman leaves.

Characteristics of battered women

- Filled with fear of the abuser.
- Ashamed to let others know of the abuse.
- Feelings of guilt.
- Socially isolated. Lack of support systems.
- Low self-esteem; distorted self-image.
- Emotionally and often financially dependent on the abuser.
- Belief that men have more rights than women.

— Unaware of existing support services.
– Hope that violence will not happen again.

In the home of a chemical dependent, violence always takes place in a particular cycle.



Cycle of Violence

1. **Tension** — Arguments, increasing criticism and building of stress.
2. **Violence** — 'Tension release' by batterer through physical violence/ or humiliation of the wife. Severity often increases in successive cycles.
3. **'Honey-moon Phase'** — Marked by apologies, gift-giving and promises. Initially, these are ignored by both spouses as violence is viewed as a 'freak event'.

In the course of time, the wife is able to see that violence does not disappear with time. On the other hand, its frequency only increases.

If so, what is it that can be done to help the battered woman?

The following is a list of the therapeutic issues that may be worked on in counselling a battered woman.

★ Battered women find it very difficult to deal with emotions like fear, anger, guilt, depression and grief. A special concern here is that of suicide, as the overwhelming negative emotions felt by battered women may result in suicidal thoughts and attempts.

★ These battered women would have had little chance to develop problem solving/assertiveness/decision making skills. They are almost always afraid of making decisions or standing up for their rights.

★ Many battered women are isolated, with few friends and no information about helping institutions. Without the ability to use available help, the task of rebuilding becomes strenuous.

Special tips for counsellors dealing with battered women.

★ Helping her to understand the cycle of violence, and the processes that perpetuate violent relationships; information on how to recognise potentially violent and destructive relationship patterns. This will be very helpful for a woman who is trying to explore whether the relationship can be saved, improved or must be ended.

★ Give supportive help and be willing to accept setbacks. The decision of how to respond, is very complicated for the woman. So she may move forward, then draw back. Reflect her strengths and fears and deal with both.

★ Provide areas to explore to help build self concept, such as accomplishments and personality strengths.

★ Help her explore options — therapy programmes, family help units, emergency shelter, legal aid, employment possibilities — so that she can consider plans realistically.

★ Women who have been battered by an alcoholic or a chemical dependent will benefit from experience in Al-Anon or similar groups. If addiction is the reason, they may need help in seeing all the damages caused by chemical dependency, while still being aware that this does not justify what has happened to them.

Special tips for counsellors dealing with abusive men

- Make him understand his violence cycle.
- If he had been a victim of abuse in the past, these emotions should be explained in depth. The family member who had been abusive should be made to attend therapy sessions so that the patient forgives and forgets the past which is important for his recovery from addiction.
- Make him realise that he has taken the role model of father or any other significant person in his life. This helps in his recalling his own bitter experiences of abuse in the past.
- Help him learn and explore alternative coping skills to deal with anger.

An implementation tool for the counsellor

Anger management during abstinence

A ready to use questionnaire for the patient

Chemical dependents state that one of the issues difficult for them to cope with, is anger. Many attribute relapses to an inability to constructively handle anger. Mismanaged anger can pose a threat to sobriety; it can also lead to problems in relationship with others.

During the patient's stay at the After-care Centre, the Counsellor can

- conduct group sessions on anger management
- express appreciation whenever the patient is able to resolve his anger appropriately.

The following steps may help the patient learn to understand, recognise and deal with anger in constructive ways.

Step – I

Recognise angry feelings

How does your anger show up? Look for anger clues.

1. Physical signs
   a)
   b)
   c)

2. Psychological signs
   a)
   b)
   c)
3. Behavioural signs
   a)
   b)
   c)

Step – II

Identify possible causes of your anger

Examine all the contributing factors related to your anger, by identifying the situation which triggered your anger, who else is involved, and why you feel angry at this particular time. List below the causes of your anger.

Step – III

Identify effects of your anger on your self and others

Examine your usual responses to your angry feelings.

For example:

a) Do you do nothing and allow anger to build up inside?
b) Do you shout at others and get into arguments or fights?
c) Do you try to ignore the situation or do you talk about your anger?
d) How does your method of handling anger affect you?
e) How does your method of handling anger affect others?

Step – IV

Decide on the best method of handling your anger

Decide first if your anger is really justified. It may be an over reaction to a situation or a result of self anger which you misplace on others. If your anger does not seem justified, try to talk yourself out of it. What are the methods you are going to adopt while communicating your angry feelings?

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9

UNDERSTANDING POWERLESSNESS AND UNMANAGEABILITY

For a chemical dependent, true recovery from addiction starts with an understanding of his powerlessness over his addiction and unmanageability in almost all areas of his life.

What is powerlessness?

Understanding powerlessness over addiction is the foundation to recovery from chemical dependency. A thorough understanding of powerlessness must be solidly and firmly established; otherwise addiction cannot be arrested.

We hear alcoholics say,

> *"If I can set right the problems in my life, I will be okay... My only problem is my job. I am not getting promoted fast enough. My boss is too prejudiced... My wife is too demanding; too critical; the family does not understand me."*

With such rationalisations, the alcoholic is failing to see his physical and psychological powerlessness over addiction.

For a chemical dependent, there is a physical dependency on drugs. He probably started drinking/using drugs to relax, to have fun, to be part of a group, to be accepted. But now, a time has come when his body has become so much dependent upon drugs that if he stops using it, he develops severe withdrawal symptoms. He is totally powerless over it.

Moreover, he is unable to exercise control over the quantity, time and place of drinking/drug taking. He has reached a point where he cannot keep away from drugs or control the amount consumed. Drug abuse has become compulsive. He tries several methods to quit on his own — to

give up drugs — not for ever, but for a specific period of time. He is able to stay away from chemicals for a period of time he has set, a week, a month or whatever — but then, his compulsion for drugs makes him either shorten the period of time he has set for himself, or he is able to abstain for the said period. In either case, after this stretch, he inevitably goes back to obsessive drinking/drug use. He attempts to change his drinking/drug taking pattern, to convince himself and show others that he can start using again without experiencing the same old problems. For example, the alcoholic changes drinks or shifts the place and time of drinking. But no matter how many changes he makes, if it is alcohol he is drinking, he is not able to exercise any control. In short, he is powerless over alcohol.

The chemical dependent lives in compulsive slavery, as drugs provide the only means he knows by which life is made bearable, or by which he can quieten his jittery nerves. Reluctance to examine his physical dependence is as much a symptom of his disease as liver damage, or any of his other drug- related physical problems. As far as chemicals are concerned, he has also developed psychological dependence. The urge to repeat the experience of becoming high is so strong that he forsakes many of his responsibilities and values. He has thrown away things that are most important to him — his family, his job, his personal welfare, his respect and integrity — in order to go after and satisfy the urge to drink/use drugs. This further demonstrates powerlessness in his life.

Acceptance of powerlessness

Understanding and accepting powerlessness is a way to freedom. The chemical dependent will be releasing himself from the insanity, the morning shakes, the loss of respect and the loss of interest in activities that have been important in his life. He will be able to get over the physical problems induced by alcohol and chemicals on his nervous system. He will not be subject to the moral deterioration and the loss of regard for his individual value systems. He should ask himself, "What am I really giving up?" — he is really giving up misery, pain, discomfort and a fight for mere existence in life.

Social pressures centred on the myth that "Will power is all that is needed to control a drinking or drug problem" can result in the chemical

dependent's unwillingness to accept his powerlessness. He should be made to understand that he cannot exercise his will power, **only** with regard to alcohol/drugs. In all other areas of life, he is absolutely capable of being in control. He has the will power to put the rest of his life back in order. He has absolute power to rebuild family relationships, to excel in his job, to have fun and lead a productive and meaningful life. So far as these areas are concerned, he could be in control, provided he totally gives up drinking/drug taking.

Initially, it will be hard for anyone to admit that he is powerless. It is infinitely difficult for the chemical dependent to admit that he is an addict. But unless and until he does, he will continue to hit his head against the wall, and his addiction will progress. Even to start recovering, it is absolutely essential that this admission is made, totally believed and totally accepted. It is the doorway to a new way of life — it means life itself.

When does the chemical dependent totally accept his powerlessness? — when he is encumbered with too many problems which he is unable to handle. He is afraid and feels terribly guilty. He slowly comes to understand and accept he cannot exercise any control over chemicals. With total acceptance, he feels relieved. He knows he suffers from a disease and consoles himself saying that his problems were the result of his addiction. Once he accepts his powerlessness, he is in a position to take steps to resolve his guilt, shame, fear etc.

Helplessness is not hopelessness

The chemical dependent is helpless with regard to drugs. Helplessness without hope could be utterly shattering. But for him, there is, however, lot of hope — a bright, shining hope, exemplified by thousands of recovering persons around the world, whose recovery began when they learnt and totally accepted that they had a disease. In other words, there should be absolute recognition of the fact that he is powerless over drugs and he will not be able to exercise any control over his drug use. In short, there should be total **acceptance**.

The first essential part of recovery is to stop using chemicals completely. If he begins to use again, he risks his health, his sanity and his life. The chemical dependent who recovers is the one who has accepted

himself as an addict. By accepting himself, he can change his own self-image from "drinker" to a "non-drinker". It is necessary to go further than to admit his powerlessness. He must completely, absolutely and whole heartedly **accept** it **(surrender)**. He must make it a part of himself, just as the shape of his skull or the colour of his eyes. He will be able to rebuild his life only if he accepts his disease and its permanence. Accepting this, is not a sign of weakness. On the contrary, it is indicative of one's strength to be honest, realistic and to recognise one's own limitations. He will learn that he will not be able to adapt his life unless he has a thorough, ongoing programme of recovery in the same way as a diabetic or a heart patient has, to keep his disease in check.

> *Let us think about a person who has lost his leg. The leg is completely severed and gone for ever. This person can do one of the two things — he can tear himself apart wishing he had his leg back, or he can face facts and accept the loss.*
>
> *If he chooses the first way of dealing with the situation, he will feel sorry for himself and resent people, who are walking on both their legs. He will envy and hate them, curse his fate, indulge in self-pity and drive himself to the brink of insanity. In other words, he will not face reality.*
>
> *The other option he has, is to face facts. He can tell himself, "I have to live the rest of my life with one leg. I cannot change this fact; so I will accept it and make the best of it." By accepting it, he opens up ways of dealing with his problem. He will learn to use crutches or an artificial leg and will be able to get along and do things that make him happy.*

The chemical dependent, like the amputee, has two options. He can refuse to accept the fact that he is powerless over drugs. He can try again and again, to use drugs with control. He will not succeed and will end up in total destruction.

The other option is to accept himself to be totally helpless with regard to chemicals. He can then go about living with hope and contentment **forgoing only chemicals**. The chemical dependent can acquire physical and mental health, gain respect and the ability to function as any other efficient person. Actually, a recovering person can make his life infinitely better, richer and more rewarding than he had ever believed possible.

Unmanageability

Unmanageability is related to powerlessness. What helps the chemical dependent to identify powerlessness, is taking an honest look at what drinking or using drugs had done to him. Instead of living a free and natural life, he is reduced to fighting for survival in life.

Addiction directly affects every area of his life, and he is unable to manage anything properly.

Physical unmanageability

He develops physical problems and his body is affected. For an alcoholic, the blood stream and body cells are first affected, then the brain, as he compulsively substitutes alcohol for the nutrition necessary for normal growth. Complications like gastritis, liver dysfunction, polyneuritis and even cirrhosis occur. His physical deterioration is quite obvious.

Emotional unmanageability

His emotions and behaviour get affected. He experiences extreme fear and anxiety. He feels intensely lonely. There are moments when he is totally depressed. He gets angry and frustrated for no proper reason and shows his resentment towards others. In other words, he is not able to exercise any control over his emotions.

Occupational unmanageability

In the area of job, lost hours and shirking responsibility are directly related to the abuse of chemicals. He loses the respect of co-workers; receives memos, and suspension orders. Sometimes, his drinking/drug taking leads to his even losing his job.

Unmanageability in family relationship

There is a total breakdown in his family relationship. As a result of the enormous problems experienced, there is lack of communication, and lack of care and warmth from the family members. Children also move away from him. Addiction results in torn family relationships.

Social unmanageability

This inevitably follows the act of drinking or taking other drugs. He becomes aggressive, gets involved in fights and even displays anti-social behaviour. To give an example, there is little doubt that for an intoxicated person driving his vehicle down the street, the situation is unmanageable.

Financial unmanageability

As a result of uncontrolled drinking/drug use, the chemical dependent is almost always unable to live within the available income. He borrows from all possible sources and is unable to repay them. So far as finances are concerned, he is totally 'broke' and his financial life becomes unmanageable.

Legal unmanageability

Unmanageability is obvious in arrests for disorderly conduct, violent fights and breaking of laws.

Recovery from addiction, the disease which was responsible for his unmanageable life, can be accomplished only when he stops using chemicals and simultaneously makes changes to improve the quality of his life.

How does an understanding of powerlessness and unmanageability help?

- ★ It makes the chemical dependent honest in evaluating his true physical condition.
- ★ It makes him humble so that he willingly stops rationalising and promising that he can stop taking drugs, using his will power.
- ★ It awakens him to the need for getting help through treatment and A.A./N.A.

Additional information

An implementation tool for the counsellor to help the patient understand his powerlessness and unmanageability

A ready-to-use assignment for the patients

If you have admitted to yourself, that you are powerless over alcohol and other drugs, and that your life has become unmanageable, it is possible that you are sad right now. Such a feeling of pain is normal. It is important to talk over feelings you are having as you look at your drug use. Talking about it, is part of accepting your disease. Not knowing the cause and not having a permanent cure does not matter. What matters is **recovery**.

Now that you know what the problem is, you can do something about it. You don't have to keep living in the mess your disease has created. Your decision can lead to recovery. You are not alone. You don't have to set right your whole life at once. Recovery starts when you begin to surrender to the fact that you are powerless over chemicals. You have already begun. You have taken the first step.

Acceptance of powerlessness

1. What was the drug you were regularly using?
2. What other drugs have you used?
   a)
   b)
   c)
3. Do you keep a secret supply of money to buy drugs/alcohol?
4. What times of the day do you usually 'get high'?
   a)
   b)
   c)

5. Give examples of moments your mind was on chemicals when it should have been on something else.
   a)
   b)
   c)
   d)
6. Have you ever tried to control your drug use, if so, when and how?
7. What happened each time?
   a)
   b)
   c)
   d)

Realisation of the fact that life has become unmanageable

Effects on the body

1. How many times have you passed out after using chemicals?
2. Do you have any disease which is caused by your drug use?
3. Did you suffer from sleeplessness, tremors or loss of appetite?
4. Has your drug use had any effect on how well you can solve problems or concentrate on your work?

Effects on emotional life

1. Have you ever felt like committing suicide? If so, when?
2. Part of recovery is learning to know and talk about your feelings. Do you feel guilty or ashamed over any of your past actions? If so, list them.
   a)
   b)
   c)
   d)
3. Even when people are around, do you ever feel intensely lonely?

Effects on the job

1. Have you received warning letters/suspension orders from your workplace? If so, how many times and for what?
2. How many jobs have you changed during the past 5 years?
3. Have you ever been asked to quit your job?
4. Have there been periods when you were unemployed? If so, give details.

Effects on family life

1. Has your wife left you or ever threatened to leave you?
2. Have you ever suffered from lack of love/trust or rejection by your wife/parents?
3. How do your children behave when you are around?

Effects on social life

1. How many friends have you dropped or drifted away from, because they don't use drugs?
2. Some other friends may have dropped you as your use grew heavier. Who are the people who went away from you?

   a)

   b)

   c)

3. List some names or terms people have used when they refer to you? (which relate to your drug use).

   a)

   b)

   c)

Effects on finances

1. List the number of times you had borrowed money and from whom.

   a)

   b)

   c)

2. Go back to your days of drug use and figure out approximately how much money you have spent on drugs.

Illegal behaviour

1. Have you ever been arrested? What is the reason?
2. Are there times you have done things you could have been arrested for but you were not caught? List them.

   a)

   b)

   c)

   d)

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10

RELAPSE PREVENTION PLANNING*

Relapse and Recovery are closely related. A chemical dependent cannot recover from addiction without experiencing a tendency towards relapse. Relapse tendencies are a normal and natural part of the recovery process. However, clear and accurate thinking helps to overcome relapse tendencies.

Recovery from chemical dependency starts with the acceptance of the fact that the person cannot safely use alcohol or any other mood altering chemicals. Abstinence from mood altering drugs allows the recovery process to begin. Total recovery, however, requires much more than mere abstinence. It is necessary to correct the physical, psychological and social damages caused by addiction. It is also necessary to learn to live a healthy and productive life without feeling the need for alcohol or other drugs.

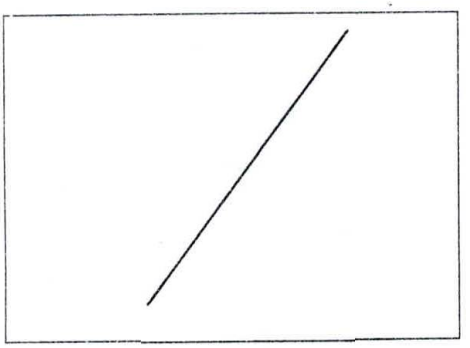
Recovery from addiction goes through distinctly defined stages

Developmental Period	Goal
1. Pretreatment	Recognition of Addiction
2. Stabilisation	Handling withdrawal symptoms and Crisis Management
3. Early Recovery	Recovery from Post Acute Withdrawal
4. Middle Recovery	Balanced Living
5. Late Recovery	Positive Personality Changes
6. Maintenance	Growth and Development

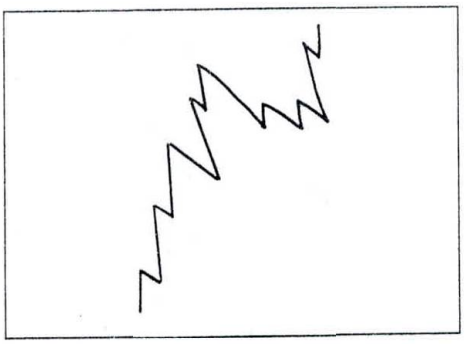
* RELAPSE' and 'RECOVERY' are dealt with in great detail in our earlier publication, "Alcoholism and Drug Dependency - The Professional's Master Guide". This chapter will be more meaningful and complete if it is viewed as an extension of the above mentioned chapters and read along with them.

One of the major problems in recovery from chemical dependency is relapse, or a return to alcohol or drug use after a period of abstinence following treatment. The dependent must be made aware that relapse is a distinct possibility which could happen to him. Recovery from addiction is an **ongoing process** requiring both **abstinence** from mood altering substances and a **change** in thinking patterns, attitudes, behaviour and life style.

Recovery from addictive disease is not a process of straight line growth*



Recovery does not progress like this!



It progresses like this!

There are certain specific problems experienced during abstinence. When these abstinence-based problems become severe the person begins to become dysfunctional even though he is not using chemicals. These episodes of dysfunction constitute the **Relapse Syndrome**. When these symptoms of the relapse syndrome make life painful, many chemical dependents choose to use drugs to gain temporary relief from the pain. Some others do not drink/take drugs; but develop serious problems related to the relapse syndrome.

* Diagram reproduced from 'Staying Sober' by Terence T. Gorski and Merlene Miller

What are the problems experienced during the initial stages of abstinence?

The relapse syndrome*

Internal and external dysfunction

- Thought Process Impairment
- Emotional Process Impairment
- Problems with remembering things
- High level of Stress
- Difficulty in sleeping restfully
- Difficulty with physical coordination
- Denial Returns
- Avoidance and Defensiveness
- Crisis Building
- Immobilisation
- Confusion and Over-reaction

Loss of control

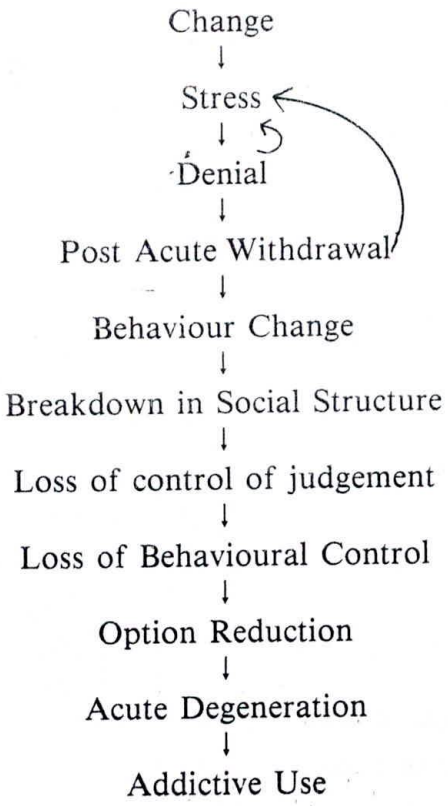
- Depression
- Loss of Behavioural Control
- Recognition of Loss of Control
- Option Reduction
- Relapse Episode

Thus, relapse is not merely the act of taking a drink or using drugs. It is a process or progression that creates an overwhelming need for the use of alcohol or drugs.

* A close look at 'Alcoholism & Drug Dependency – A Professional's Master Guide' will give better clarity about the problems associated with Relapse Syndrome.

What are the different stages in the progression of relapse?

The relapse progression*



It is possible to interrupt the relapse progression before serious consequences occur by bringing the warning signs of relapse into the chemical dependent's conscious awareness. This is **Relapse Prevention Planning**.

The **Relapse Prevention Plan** includes educating the patient about the relapse process and devising a plan to help him understand the warning signs of relapse so that he can prevent a return to drug use.

* This is dealt with in great detail in 'Alcoholism & Drug Dependency – The Professional's Master Guide'. (Reproduced from 'STAYING SOBER'. A guide for Relapse Prevention by Terence T. Gorski and Merlene Miller)

The chemical dependent can be in a relapse before he actually uses alcohol or drugs. It is possible to build up to a relapse over a period of days, weeks or even months. Many alcoholics and chemical dependents have reviewed their relapse experiences and identified **clues** which preceded their return to the use of chemicals.

Relapse clues or warning signs may relate to changes in attitude, thoughts, feelings, behaviour, or a combination of these. The dependent should be made to understand that he must be on the alert when changes occur so that he can avoid a return to chemical use. The following are some examples of "relapse clues".

1. **Changes in attitude**
   - Not caring about sobriety
   - Becoming too negative about life

2. **Changes in thought**
   - Thinking that he "deserves" drugs because he had been sober for quite some time.
   - Thinking that he can use substitute drugs.
   - Thinking that his problem is "cured" since he had been abstaining for sometime.

3. **Changes in feelings**
   - Increased moodiness or depression
   - Strong feelings of anger and resentment
   - Increased feelings of boredom and loneliness

4. **Changes in behaviour**
   - Increased episodes of arguing with others
   - "Forgetting" to take Antabuse
   - Skipping AA/NA meetings
   - Stopping in a bar just to socialise and drink soda or other soft drinks
   - Increased stress symptoms such as smoking more cigarettes
   - Threatening to use drugs to have his way
   - Talking repeatedly about the pleasures associated with chemicals

These are just a few examples. The important point to remember is that negative changes in attitude, thoughts, feelings and behaviour indicate that the relapse process is set in motion.

After the identification of warning signs, the chemical dependent should be helped to explore healthier ways to replace them. He should be helped to lower the risk of experiencing relapse through guided focus, structured exercises, relapse prevention planning and contracts. Planning for relapse prevention minimises its destructive potential. This planning will give him a sense of security. He will be able to identify early warning signs and develop a plan for interrupting the relapse syndrome if it appears. Relapse Prevention Planning should be an essential part of his recovery programme.

Various steps in relapse prevention planning

★ Stabilisation

"I must get back in control of myself and my behaviour."

Stabilisation is the method of regaining control over thoughts, emotions, judgement and behaviour, when a person is in the relapse process. This will be a time of crisis for him and his family. He may feel frightened, angry, disappointed and guilty. At this point he needs help.

Vitamins and other medicines to help him regain his normal physical health may be his immediate requirements in the process of getting physically stabilised. This is the time the Counsellor could reassure him and help him take necessary steps to re-establish his sobriety.

★ Assessment

"I must find out with the help of others, what is causing my relapse episodes."

The second step in Relapse Prevention Planning is to identify the factors that set his relapse in motion. This can be traced by reviewing his history of addictive use, as well as finding out the specific warning signs that occurred during each period of attempted abstinence. This information will provide valuable clues as to what went wrong and how it can be rectified to improve chances of the dependent's permanent sobriety.

Suraj, 40 years old, was running his own departmental stores. He underwent treatment for his alcoholism. He was responding well during the initial phase and maintained

abstinence for one year. After 12 months, he went back to drinking again. He was again detoxified and treated. This one year mark became his relapse pattern. On the third year, after three relapses, he started thinking - "My God! what is happening to me? Why is it I am not able to abstain? I should definitely do something about this."

He approached the Counsellor and an open discussion and analysis revealed that his drinking was triggered by the stress he experienced during every 'year-end' on the period of closing of accounts. Now that he identified the episode which caused his return to drinking, he was able to work out a practical plan with the help of the Counsellor and start implementing it straight away.

★ Relapse Education

"I must learn about the process of relapse, and methods to prevent it."

The more information the chemical dependent gets about addiction, recovery and relapse, the more tools he will have to maintain sobriety. He has to understand post acute withdrawal symptoms, what puts him in high-risk of developing them, what might trigger them and what it takes to prevent or manage them. The Counsellor should help him review and apply this information. The education programme will be complete only when he is capable of honestly and openly applying information to his own life and his current life circumstances. Addiction is a disease of denial; and his denial may prevent him from recognising what is really happening to him.

Lakshmanan was a 35 year old ganja addict with a history of heavy drug taking and related problems for the past 8 years. He had been hospitalised quite a number of times and participated in many recovery programmes. While reviewing his relapse history, he stated that he usually built up to drug taking over a period of about 5 weeks. His relapse clues included

1) Decreased interest in taking care of his nutritional needs which was evident when he skipped breakfasts and dinners.

2) *Increased thoughts of smoking ganja such as "I can have a few puffs."*

3) *Stopping in the den where he used to smoke ganja in order to "see old friends."*

The following relapse prevention plan was devised by Lakshmanan with the help of the Counsellor.

★ *When I notice that my food habits are changing, I must find out why this is happening and whether something is bothering me which needs attention.*

★ *I must see my Counsellor/N.A. sponsor to review my current feelings.*

★ *I must go regularly to gymnasium to regain my physical fitness.*

★ *I must write in detail why stopping in the den is not in my interest.*

★ *I must review the benefits of sobriety which I have already written, in order to reinforce the importance of my recovery.*

★ Warning sign identification

"I must make a list of my personal relapse warning signs."

Relapse warning sign identification is the process of identifying the problems and symptoms that can lead to a return to chemical use. Problems may be situations outside of the chemical dependent or within. Symptoms may be health problems, thought problems, emotional problems, memory problems or problems with judgement and behaviour.

It is necessary for the patient to develop a list of personal warning signs from past relapse experiences. He should be helped to develop a list of clear and specific indicators that denote that he is beginning to move towards drug use again.

Anil, 50 year old, alcoholic, widower, employed, has had sober periods upto 2 years. However, since his wife died, he had been drinking very heavily with only short periods of abstinence. His high risk situation was his "painful memories"

of his wife's untimely death and related feelings of sadness and depression. Anil usually experienced these memories and feelings on certain holidays, the anniversary of his marriage, and sometimes during the weekend when he was at home all alone.

In working out his relapse prevention plan, Anil decided to utilise professional counselling to assist him in working through his sadness, depression and grief. Should painful memories or feelings regarding his wife make him feel like drinking alcohol, he will discuss these immediately with his Counsellor/A.A member or his sister. Prior to the holidays and other times associated with his negative feelings, he decided to make plans to become more active in A.A. and visit his elder sister and her family and take their children out.

★ Warning sign management

"I must have concrete plans to interrupt the warning signs before I lose control."

Addiction is a disease with a tendency towards relapse. Once the chemical dependent knows and accepts that fact, he can plan for the inevitable. Each warning sign is a problem he has to solve once it occurs. He will need to review each warning sign and answer the question, "How can I prevent this problem from happening?"

The chemical dependent should keep a daily record to review his recovery process and monitor for relapse warning signs. This will help him see whether he is making progress in his recovery. Just knowing what the warning signs are, may not necessarily help him. It is essential for him to establish new responses to the identified warning signs. He has to be guided to determine what he is going to do when he recognises a specific warning sign which shows itself again and again in his life. He should be helped to get clarity on the following questions:

"How can the relapse syndrome be interrupted?"

"What positive action can I take to deal with the warning sign?"

He should list several options or possible solutions for tackling these problems in his life. Listing several alternatives will give him better

chance of choosing the best solution and provide him with alternatives in case his first choice does not work. The chemical dependent should be made to understand that he has to practise each new response until it becomes a habit. If the new response is to be applied in times of high stress, he can practise it in times of low stress. If the new response fails to interrupt the warning sign, he has to establish a more effective plan. He cannot afford to put off developing a plan to interrupt his warning signs as and when they occur. If he does not have a ready plan, he will not be able to interrupt any warning sign at all.

Here is a chart prepared by Madhan, a recovering addict.

Warning signs	**Management techniques**
Meeting a drug user	Immediately leave the place and meet an N.A member
Loneliness Boredom	Get involved in activities like going with the children for a walk
An urge to take drugs	Visit a temple Get something to eat Postpone use of drug till the next day
	This method can be renewed again the following day Go through the already prepared list of all the bad things that happened during my active drug taking days
	Think of how good I feel and how people respect me when I do not use drugs
	Think of slogans like "Easy does it" or "This too will pass".

★ Inventory Training

"I must do an inventory twice daily, so that I can notice the first warning signs and correct the problems before they go out of control."

Any successful recovery programme involves a **daily inventory**. This is necessary to help him identify relapse warning signs before his denial gets reactivated. Any relapse warning sign is serious because it can be the first step towards his getting back to drug use. Without a daily inventory, the chemical dependent is likely to ignore early warning signs, and then be unable to interrupt the relapse syndrome when it becomes obvious.

The chemical dependent should be helped to develop a way to incorporate this inventory system into his day-to-day living. In order for the daily inventory to become a habit, the establishment of two daily inventory systems can be recommended to him. The first can take place in the morning. He should plan activities for the 24 hours of that day. He should ask himself whether he is prepared for that day and what action he is going to take to physically and emotionally meet the challenges of that day and maintain sobriety.

The second inventory can take place in the evening. Now he has to review the tasks he had undertaken and identify those which he handled well and those which needed improvement. He can list the strengths he displayed in meeting the challenges and find out methods to reinforce and build upon his strengths. He can also think about his weaknesses and find out methods to overcome his shortcomings.

> *Arjun, a 35 year old employed man, got treated for his alcoholism. Six months after completing the programme, four of his old 'friends' came to meet him. In the course of conversation, one of them suggested that they go on a picnic to a nearby place on the New Year eve. Arjun was immediately thrilled with the idea and enthusiastically said he would join them. When they had left, after about an hour, he suddenly realised he was getting into their trap. "My God! How silly I have been! Their only source of enjoyment is drinking. How is it that I forgot about it and got thrilled with their idea!*

No! I will not go. If I go, I may not be able to resist the temptation of drinking." He decided to inform them that he would not be able to accompany them. How could he do it? He thought of a few ways.

- *State straight out that I have a problem with alcohol.*
- *Politely refuse to come, without giving any explanation.*
- *Offer an alternative activity. For example tell them "I am not drinking, let us enjoy going to a temple."*

He finally decided that the second option was the best and immediately rang them up and politely declined their offer.

★ A review of the recovery programme

"I must review my current recovery programme to make sure that I am managing my warning signs well."

The Counsellor can help the chemical dependent find out whether his previous recovery programme had been working for him or whether it can be improved upon. For every problem, symptom or warning sign that he had identified, he should ensure that there is something in his recovery programme to help him cope with it.

★ Involvement of significant others

"I must get feedback from others as to whether they are able to identify any warning signs of relapse in me."

It is not possible for a chemical dependent to recover in isolation. Total recovery involves the help and support of a variety of people. As the relapse process sometimes happens at the unconscious level, in spite of the daily inventory, the chemical dependent may not be able to see what is actually happening to him. That is why it is important to involve other people in Relapse Prevention Planning. Family members, co-workers and fellow AA/NA members can be extremely helpful in recognising warning signs.

Sometimes people even when they recognise the warning signs, may find it difficult to tell the recovering person that he is relapsing. They may be afraid that in case they openly tell him, he will become angry

and show his resentment by drinking. They will be more comfortable in informing the Counsellor so that the Counsellor, in turn, tells the patient without arousing his resentment. In order to facilitate this, the Counsellor may hold weekly meetings with the family members and other significant people so that they openly discuss the relapse warning signs which they have observed in the chemical dependent.

The chemical dependent must be made aware that he should allow the network of significant people to participate in his recovery. He should encourage them to verbalise their feed back as to whether he is showing any warning signs.

★ Follow-up and Reinforcement

"I must revise my Relapse Prevention Plan as I grow and develop in my recovery."

Chemical dependency is a life long chronic condition; and recovery from addiction is a way of life. Since Relapse Prevention Planning is a part of recovery, it too must become a way of life. This planning should be integrated into his entire life, and must be compatible with AA/NA and other support groups he is using to maintain sobriety.

The recovering person has the freedom to carefully choose methods that will help him grow and develop. He must be willing to revise and update his plans at regular intervals and be willing to recognise new problems that pose a threat to his sobriety. In short, Relapse Prevention Planning is a process that should become an integral part of his recovery. For him, the outcome will be freedom to enjoy a comfortable sobriety and assurance that he has an action plan to manage any warning sign if it develops.

Additional information

A model relapse prevention planning programme

Following is a treatment model which allows the Counsellor and client to recognise forces that maximise the potential for recovery. This can be done by

- obtaining information about the patient's current level of functioning
- identifying positive and negative forces in relation to sobriety
- identifying problems and developing goals
- treatment strategies
- evaluation

This model is applicable within any treatment facility where there is an emphasis on individualised treatment planning.

Bharath, a 25 year old electrician, married, had problems with Brown Sugar for the past 5 years. His drug taking was stress related and occurred when peers were around. Bharath's wife refused to allow him to live in the house when he was using drugs. During those days, he stayed with his old drug taking 'friends'. Bharath recognised his problem and got admitted in the After-care Centre since he wished to achieve sobriety and was afraid of losing his wife. After discharge, Bharath had several periods of abstinence ranging from 3 to 6 months with N.A. participation.

Recently, Bharath had some problem at the office which demanded overwork and this caused stress. As a result, he could not attend N.A. meetings. When he met one of his drug taking 'friends', he was almost on the verge of going back to drugs. He immediately consulted the Counsellor at the After-care Centre to prevent a relapse.

Obtaining Information

The purpose of this step is to gather information about the chemical dependent in order to assess his current level of functioning. A comprehensive assessment is obtained by gathering information about

the client's behaviour in different areas — emotional, environmental, family, vocational, physical and interpersonal.

Such information can be obtained through interviewing, psychological testing etc. In this case, the counsellor should spend time with Bharath, his wife, parents and employer. During this process, the counsellor establishes a therapeutic relationship with Bharath and explains the purpose of obtaining this information. Once this information is obtained, Bharath and his counsellor will begin to organise information into a system that allows them to understand the impact of various forces on his sobriety.

Identifying positive and negative forces in relation to sobriety

Forces are feelings, thoughts, needs or behaviour of the chemical dependent and/or in the person's environment which enhance sobriety (positive forces) or those forces which jeopardize his sobriety (negative forces). It is necessary to understand these forces operating for or against a client so as to maximise successful rehabilitation outcome. Once these forces are identified, positive forces can be strengthened to facilitate sobriety; negative forces may be weakened to enhance the person's potential for achieving sobriety.

A review of Bharath's experience indicates the following positive and negative forces:

Positive	Negative
Previous N.A. participation	Difficulty in handling stress
Previous periods of abstinence	Drug-taking influenced by peers
Recognition of the drug problem	
Desire to achieve sobriety.	

Identifying problems and developing goals

When each problem is clearly stated, specific goals can be formulated. The following format which can be applied to each significant force, is presented as a guide for the development of problem statements, goals, and counselling activities.

Let us examine Bharath's case.

Problem statement

Bharath did not maintain and follow through his N.A. meetings.

Force which can bring about the change	Previous N.A. involvement
Goal	Bharath will become reinvolved with N.A. on a regular basis.
Counselling activities	a) Explore with his help, previous involvement with N.A. and the nature of assistance he gained from it. b) Discuss with Bharath the reasons why he stopped going to N.A. meetings. c) Help him identify a sponsor in N.A. d) Discuss with Bharath the number of weekly N.A. meetings he feels he needs to attend. e) Explore with Bharath reinforcers which would assist him in following through with N.A.

Treatment strategies

The purpose of this step is to identify strategies so that the goal is accomplished. These strategies should be realistic and attainable.

In Bharath's case, the following can be the treatment strategies.

a) Meet Bharath twice a week for individual sessions to explore goal areas.

b) Establish a written contract with Bharath for his weekly attendance of N.A.

c) Talk with Bharath's wife and parents to determine their interest and willingness to attend Al-Anon and Family Counselling sessions in order to increase their understanding of how to help Bharath.

Goals and treatment strategies need to be established to address his stresses. It will be helpful to involve him in group therapy sessions.

After Bharath has established a stable period of sobriety and his wife has received help for herself, marital counselling may be necessary to improve their communication and support system.

Evaluation

The final step evaluates the process and outcome of the assessment, goal setting and treatment planning. The following questions may be used as an evaluative measure to assure the comprehensiveness and quality of treatment efforts.

1) Is the assessment information comprehensive, and clear?
2) Have all the positive and negative forces been identified? Are those the correct forces?
3) Are the specific problem statements, goals, and counselling activities for each force realistic and attainable?
4) Have effective treatment strategies been outlined to accomplish goals?

This model allows the Counsellor and client to become actively involved in a process to maximise the potential for recovery. This process includes identifying the forces, enhancing sobriety and the forces jeopardizing sobriety, and utilising the counselling process to develop action plans necessary to increase and decrease appropriate forces. This Relapse Prevention planning model can be easily integrated into the existing treatment structure of any After-care treatment facility.

An implementation tool for the Counsellor

Following is a tool which can be effectively used by the Counsellor when he is guiding the chemical dependent towards relapse prevention. The purpose of this questionnaire is to help the chemical dependent understand relapse as it relates to his situation. This will

- ★ Provide him information on important topics related to relapse.
- ★ Give him some practical ideas which will help him minimise the chances of relapse.
- ★ Help him take responsibility for identifying specific high risk relapse factors which could lead to his abuse again.
- ★ Help him begin to make specific prevention plans based on his life situations.

Following are questions, which the Counsellor can ask the chemical dependent to answer, so that he is assisted in devising his own relapse prevention plans.

I. Understanding the relapse process

If you have experienced a period of recovery in the past, prior to a relapse, answer the following:

1. What **specific clues** or **warning signs** preceded your relapse?
   a)
   b)
   c)
   d)
   e)
2. How much **time lapsed** between the emergence of relapse clues and the actual use of alcohol or drugs?
3. If these warning signs were to occur again, what **specific steps will you take** to prevent a return to drug/alcohol use?
   a)
   b)
   c)
   d)
   e)

II. Identifying and managing the warning signs

During recovery, especially during the initial stages, it is very common to experience an uncontrollable urge to use alcohol or drugs. Have you experienced such urges? If so, think over and answer the following:

1. What triggered your urge to take alcohol/drugs?
2. What was the physical discomfort which made you think of going back to drinking/drug use?
3. Describe briefly your mental condition which triggered your thought of drinking/drug taking again?
4. List the specific steps you have decided to take from now on to prevent a return to alcohol/drug use.
   a)
   b)
   c)
   d)

III. Involving significant others

It is difficult to achieve sobriety without the help of others. Therefore it becomes essential to get others seriously involved in your Relapse Prevention Planning. Have you planned such a network? If so, answer the following:

1) Who are the sponsors you have identified?
2) Are those significant people aware of all the relapse warning signs?
3) In case they identify any warning signs in you, what is the method by which they are going to bring it to your notice?

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11

ADDICTION — ITS IMPACT ON THE FAMILY

Addiction is a 'family disease' in every sense of the term. Treatment professionals should recognise that addiction cannot be treated in isolation; improving patient's relationship with wife and other family members is an essential element in treatment.

Parents, wives and sometimes even children believe that it is their duty to try to control the chemical dependent, and stop his use of drugs. This results in those involved in close relationships becoming as preoccupied with the individual, as he is with drugs. When those who have concern for the patient 'cover up' for him, they unwittingly enable him to progress further into the disease by becoming his care-takers. Addicted people take advantage of the vulnerability of their families or friends, and manipulate them. Without that protective support system, they would not be able to continue with their drug use and survive. When the wife or parent covers up, pampers, pays back the debts, pretends nothing traumatic has happened, she does it because she wants to protect the dignity of the family and also because she does not want that person to be upset. She does not want to rock the boat in case it provokes the use of more drugs. Unknowingly, by doing this, she is allowing the dependent to continue behaving in an irresponsible way and endorsing what his denial system is already telling him — that the situation is not that bad.

The family's reaction to the chemical dependent

In coping with the tension and confusion which surrounds the disease, the family members experience feelings and display behaviour patterns similar to the chemical dependent's. The family members sometimes let their preoccupation with the chemical dependent cause pain to themselves and destroy their lives.

Denial

The family of the chemical dependent deny the existence of the problem in order to avoid humiliation and embarrassment. What is obvious to others, is flatly denied by those who live on intimate terms with the dependent. The family becomes quite adept at shielding the dependent, making excuses for his behaviour, helping him out of tight spots, covering up for him with his employers and others. To the outside world, the wife or parent acts as though every thing in life is normal. They fail to see their own dependency — their dysfunctional behaviour. The minimising and rationalising of the family member is often deeply ingrained and truly believed — ingrained and believed in much the same way as the minimising and rationalising of the addicted person. As a result, the family member protects the person, denies that the relationship is troubled, and denies the addiction of the person to whom she is attached.

They try to cope with the pain and trauma by putting up a brave front. But inside, they are torn apart with the agony of shame, despair, fear and a feeling of worthlessness. Even to themselves, they may minimise the extent of the problem. The chemical dependent may be abusing his family while under the influence of drugs; yet, the parent or wife reassures herself that "things are not really that bad" or "I don't think he has become addicted, yet."

Blaming

Unfortunately, the family members start blaming each other. Very often, the chemical dependent, who is trying to take the focus off himself, uses the situation to his advantage and sets one family member off against another. For example, he may tell his mother that he is using drugs because he is unhappy in his marriage. He may say that his wife nags him continuously and he can't stand it. To his wife, the same person complains bitterly about his domineering mother who never made any effort to understand him as a child and sent him away to a boarding school. This results in more pain and tension in the family because the two women start blaming each other for his addiction. In so doing, the family is kept from coming together and addressing the most important issue of how to help the chemical dependent recover from the disease.

Preoccupation

The preoccupation of family members with the chemical dependent is similar to his obsession for drugs. Their entire thinking revolves around the dependent and they forget to take care of their needs. Their lives are modified to suit the needs of the chemical dependent. Acute stresses drive the wife or parent to some behaviour or activity which she compulsively performs. For example, she may be tracking down the movements of the dependent all through the day, even though she might be aware that by doing this, she could not control his drug use. Her compulsive preoccupation drives her to waste her energy in unproductive ways, and the result is that she fails to perform her duties like cooking, looking after the children etc. She finally ends up in a self-destructive trap, controlled and manipulated. She tries all possible methods to make him give up drugs. But none of the methods work. Worry takes over the family — worrying about over dosing, about his physical health, about his being caught by the police and about what to expect next. Family members become so tense, afraid and angry that they begin to question their own sanity.

Bargaining

Bargaining also comes into play as the wife and parents try to cope with this threat that has invaded their home.

> *"I will do whatever you want if only you quit smoking ganja. I will ring up your college and tell them that you are sick, provided you stop using ganja from now onwards."*

The goal of bargaining is to offer the chemical dependent something in return for his desired behaviour. But such bargaining does not work at all. Instead, it leads to their frustration and depression.

Depression

Eventually after so many promises, bargains and perhaps even sober periods which have raised hopes and expectations, only to have them dashed repeatedly in new rounds of drug taking, those who are closest to the chemical dependent may plunge into depression, a feeling of

complete and utter hopelessness — "Is there no answer to the problem?" This is the stage that may be entered any number of times during one's relationship with the chemical dependent. The family may suddenly realise that loss of income and consequent problems are imminent or they may be saddened by the thought that his health is deteriorating and death is more or less inevitable.

Suppressed anger

The wife/parent's efforts to control the chemical dependent do not pay off. And as attempts to control increase, the dependent becomes less and less controllable and she feels frustrated and angry.

She suppresses her anger. As time passes, her mind becomes a storehouse of pent up memories, hidden resentments, hurt feelings and unresolved conflicts. Eventually, the chronic stress of unresolved emotional hurts become manifest in serious health problems — ulcers, hypertension, heart disease, etc. Her energy and vitality diminish.

Her repressed anger leads to a temper that explodes over trifles, frequent feelings of disappointment in others and a feeling of being let down. She avoids relatives and friends. Suppressed anger does not protect, it does not make life run more smoothly. On the other hand, relationships become more difficult to handle. It destroys everything that the family hopes it will protect.

Isolation

Living with a chemical dependent can be a very lonely existence. The wife and parents believe that no one else would understand their problem and that no other family has been through such pain and conflict. Repeatedly hurt and rejected, she has learnt to keep sensitive feelings inside. She keeps herself cut off from all sources of potential support. The result is that her loneliness increases and gets intensified. With loneliness and isolation, come fear and anxiety. She feels totally powerless. Yet she compulsively tries to handle all situations. Feeling the need to take charge, and at the same time feeling powerless, she lives with a great deal of ambiguity, uncertainity and fear — fear of

abandonment, loneliness, and rejection. As a result of these feelings of alienation, of low self-esteem, together with the lack of communication and bitterness in the family, the family members feel deeply alone.

Change of Personality

The disease of addiction can bring about changes in the personalities of members of the chemical dependent's family as well. People who had been loving, tolerant and patient, suddenly find themselves becoming aggressive and bitter as they struggle to cope with addiction. Many parents and wives have coped with difficult problems in life, yet the traumatic experience of living with the addicted individual leaves them depressed, disorganised and disillusioned.

Co-dependency of family members

As a result of living in a problematic environment, the family members unconsciously develop 'co-dependency behaviour patterns'.

What is co-dependency?

"Co-dependency is a specific condition that is characterised by preoccupation and extreme emotional dependence on a person. Eventually, this dependence on another person becomes a pathological condition that affects the co-dependent in all other relationships." — Sharon Wegscheider-Cruse.

The family members of the chemical dependent become preoccupied with trying to sort out his life in a meaningful way. In many respects, their frantic efforts to change the chemical dependent become as compulsive as the behaviour of the dependent person. "Co-dependency is a pattern of living, coping and problem solving created and maintained by a set of dysfunctional rules within the family system. These rules interfere with healthy growth and make constructive change very difficult, if not impossible."

Co-dependents suffer from a set of emotional problems. Their strategies of minimising, protecting, controlling, bargaining, appealing are classic

coping reactions to the chemical dependent's maladaptive behaviour. The co-dependent suffers from

- Difficulty in accurately identifying and expressing feelings.
  "I decided not to get angry when he entered home. But I could not help shouting. What is wrong with me? Am I going crazy?"
- Difficulty in maintaining close relationships.
  "I know I'll feel lighter if I share my problems with my mother. But I am unable to open up!"
- Unrealistic expectations for self and others.
  "Somehow or the other my son should get into a professional college. I don't know how he is going to do it! But he can't afford to let me down."
- An exaggerated need for others' approval in order to feel good.
  "My friend said, 'You must be a saint. I don't know how you put up with him. If I were you, I would not have tolerated him.' I should live upto this image."
- Difficulty in making decisions.
  "I need a change. I want to go to my parents' place for just one evening. Should I go? Is it right? My God! I am unable to decide."
- Anxiety about making changes.
  "I have got a job. I need money. Should I accept it? Will I be able to go? I'm scared."
- Feeling responsible for others' behaviour.
  "He is going out. He may start drinking again. I should send someone to watch him."
- Fear of abandonment.
  "What can I do if he leaves me and goes out of the house?"
- Avoidance of conflict.
  "He has not given me any money this month. How am I going to manage? Anyway I'll not ask him. He may get upset and start using ganja again."

– A sense of shame and a low self-esteem.

"I cannot talk well. I'm inefficient. I don't want to meet anyone."

Co-dependents appear to be self-sufficient, strong and in control of their lives. But beneath the public image of strength and security, often lie the opposite feelings of insecurity, self-doubt and confusion.

Thus, the people who are close to the chemical dependent do suffer a lot due to his addiction. Although the chemical dependent experiences emotional turmoil, his awareness is numbed by the drugs he has in his system. On the other hand, family members have to bear the pain of reality. So they really need a lot of help, support and understanding.

Help for the family

During recovery, the family members should be made to feel the need to detach themselves from the problem which had all along been the sole focus of their lives. If they want peace of mind, they have to be prepared to work through this process. They will find it a great relief when they stop denying the problem and pretending all is well. In course of time it will help both the dependent and the family member if they start facing the problem by doing the following.

– Stop trying to convince themselves that "if only he decides, he can always give up drugs." They have to accept that it is a serious problem which requires professional help.

– Start talking calmly and factually to the chemical dependent about his drug use and subsequent behaviour when he is drug free. The more open they are, the more uncomfortable they will make him feel, about his use of drugs. He should be made to understand that he has a disease and that he can recover.

– Start communicating honestly and openly to the other members in the family about their concerns.

– Start accepting that they are not alone; they have choices and they need the support of Al-Anon and similar self-help groups to cope with the problem. Self-help groups will help them find ways of changing and building up their self-esteem.

- Start looking after their own needs and the needs of their children. They should realise that they have to start doing their duties which they have neglected so far.
- Identify positive methods of diversion like going to temple, spending time with children, pursuing hobbies etc. Good experiences will give them the energy to face problems.
- Plan one day at a time and start executing their plans.

Problems experienced during recovery

Recovery of the chemical dependent brings a great deal of joy to everyone concerned. The family members may hope that life is going to take a turn for the better at once. They may feel that all their tension will disappear. In a supportive environment, the Counsellor should make them understand that it would be very unrealistic to expect that everything is going to be wonderful immediately. They should be made aware of the fact that there are certain problems which they may face during the patient's recovery. An understanding will help them handle the problems effectively.

★ During recovery, it is possible for the family members to experience great relief over his abstinence and yet miss the old, familiar life-style. Although it was painful, there had always been some predictability. They knew how he was going to behave, what situations they would be required to handle, etc. But now the recovering person is likely to be more independent and more demanding. This can leave family members resentful. All along, the chemical dependent would not have reacted to anything happening at home. Now he may expect his wife to make tasty dishes, keep the house clean, help the children in their studies etc. The family may not be able to view his expectations as justified.

★ Friends and relatives would all along have admired the tolerance of the family member and would have praised her for bearing the brunt all alone. When the chemical dependent stops taking drugs, the positive comments are likely to be transferred to him. They may even pick on her. "Now that he has given up drugs, why don't you be more understanding? Why do you unnecessarily get angry and

shout like this?'' These remarks hurt them and it is very common for the close family members to experience extreme bitterness and resentment, especially if they had coped with addiction by suppressing all their feelings.

★ Certain actions that would not stir a second thought if displayed by others, may set off alarms in the minds of loved ones when exhibited by the recovering person. It is virtually impossible for the family not to harbour doubts when, for example, they find some cash missing or when they find the recovering person moody, tired or notice him remaining extra long behind a locked door or getting phone calls at unusual hours.

★ The family members may treat the recovering person as a ''brittle doll''. This is the result of a continuing fear and a prolonged belief that anything they might say could cause conflict and make him go back to drugs. To give an example, the recovering person may come home in an autorickshaw. His mother may feel that he need not extravagantly spend money like that, when they could ill afford even the basic necessities. But she will not open her mouth for fear that it might upset her son, and he might get back to drugs. As a result, there is no communication, no clarity of roles and they work according to his expectations because they are afraid of upsetting him. There is no chance of mutual trust developing in this kind of relationship because it continues to be dominated by fear. On the other hand, it will only result in lot of stress for the family.

★ Family members may continue to have a resentment towards the patient for being a drug abuser. Brothers may have a negative attitude towards the patient and criticisim is likely to flow freely. Repeated remarks about money wasted on drugs and on treatment will be voiced by family members.

★ After many years of embarrassment and humiliation, the family may have few outside interests or friends. All other adjustment problems will be intensified by the family's lack of social contacts and shared pleasures.

★ Family members will find it very difficult to listen to the recovering person or relate to him in a meaningful way. Even though he may be making positive changes, they may not acknowledge; instead they may expect him to make changes according to their expectations. For instance, they may make plans for his future. They may ask him to go for work in the mornings, attend classes in the evenings, etc., without discussing the issues with him. They are likely to feel that they have solutions to all his problems.

★ The family members may have conflicting views if it comes to the question of giving him responsibilities. The recovering person may be willing to take up certain responsibilities; but the family may find it comfortable to assign him certain other responsibilities. They may not be able to trust him with the responsibilities he wants to carry out. For instance, they will find it comfortable to entrust him with insignificant jobs like carrying vegetables, participating in physical work, etc., whereas more important (and to the dependent, significant) jobs like drawing money from the bank, paying bills etc., will be entrusted to other members.

The Counsellor must help the family realise that the family support system surrounding the recovering person will require some changing. Parents/wife need to alter their attitudes and behaviour towards the recovering person. Even if one person in the family network is willing to change, it will have very positive results. The Counsellor should make the family member understand that she need not continue suffering constant emotional pain. She has to give up her preoccupation and obsession with the chemical dependent and, while still caring, leave him free to face reality and make some choices of his own. Initially it may not be easy for them and they will probably need on-going help. Al-Anon and similar self-help groups for relatives of chemical dependents will provide a good deal of constructive advice and support. There they will meet people who have gone through situations similar to their own. They will understand and identify with the fear, the feelings of helplessness and despair, the worry and guilt and the problems in learning to 'let go' of the chemical dependent. The family members

really need and deserve help to recover from this extremely painful family addiction. If they change, it is much more likely that the chemical dependent will want to change too.

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12

SEXUAL PROBLEMS IN RECOVERY

The inter relationship between chemical use and sexual activity has been established over a period of time. Sexual problems in chemical dependents are multifaceted, and call for its management, an inter-disciplinary approach.

What is sexuality?

Sexuality is in the broadest sense, the Psychic energy which finds physical and emotional experience in the desire for contact, warmth, tenderness and love. Sexual response can be divided into three phases — the desire phase, the excitement phase and the orgasm phase. The first phase or the desire phase is the libido, or the drive. These drives are influenced by hormones and are dependent upon the physical health, emotional state and presence of a suitable partner. The second phase is the excitement phase. In men, this will reveal itself in the erection of the penis, and in women, it is the vasocongestion. With continued stimulation, the reflex response resulting in regular contractions of pelvic area muscles in women and ejaculation in men will follow. This reflex action is called orgasm.

Alcohol, drugs and sex

With chemical abuse, sexual problems occur in all three phases of the response cycle. As the disease of chemical dependency progresses, damage to the brain cells and internal organs occur. Thus sexual responsiveness will first be hindered and later destroyed. Frequent depression, and troubled relationships brought on by chemical dependency will hinder sexual desire from an emotional level.

Chemicals affect the excitement phase by either sedating or 'burning out' the necessary nervous system reactions for erection in the male and eventually put such a high strain on the nervous system that

once again, responsiveness is lost. Finally, the loss of ability to become aroused often brings about low self-esteem and depression, which, in turn, serve to further lower sexual desire. In the orgasm phase, the nervous system reflex response gets blunted and often eliminated by ongoing chemical use. The most important issue is that in the relentless progression of chemical dependency, chemicals eventually destroy ability to enjoy sex.

Effects of alcohol on sexual functioning

Early phase	Middle phase		Chronic phase
Small dose	Moderate dose	Large dose	Chronic alcoholism
Release of inhibition	Longer fore-play	Impotence both erectile and ejaculatory	Decreased testosterone
Increased aggression	Increased time for erection	Disregard for social norms	Loss of sexual satisfaction
Increased desire	Difficulty in maintaining erection	Upleasant ejaculation	Erectile Impotence
Increased arousal	Uncertain orgasm	Aggressiveness	Loss of libido
Control of premature ejaculation	Decreased penile tumescence		Breast development
Decreased penile tumescence			Decreased body hair Shrivelled testicles

Effect of drugs on sexual functioning

Type of Drug	Problems due to abuse
Narcotic Analgesics	Reduced libido, erectile problems
Stimulants	Impotence
Depressants	Erectile problems, reduced libido
Cannabis	Sterility, prolonged use causes reduced sperm count and decreased sperm motility.

Assessment of sexual problems

In order to deal with sexual problems and to formulate a treatment plan, the counsellor should make an attempt to assess the exact nature of the problem.

Some individuals due to lack of knowledge, anxiety and inexperience, may exaggerate their problems. Support, information and reassurance may be adequate to resolve their problems. Some others who do have problems, may not disclose. In such cases, an empathetic and caring Counsellor after gaining the patient's confidence can probe in a supportive manner and help him to come out with his problems.

The key questions in diagnosing are

1. What stage of the sexual response cycle is impaired — desire, excitement or orgasm phase?
2. What is the degree/extent/nature and severity of the impairment?
3. How does that affect the individual? The couple?
4. Is the problem organic or psychological?

Primary vs secondary to a psychiatric problem

It is useful to assess if the patient has a psychiatric disorder. If the problem is found to be secondary to a psychiatric problem, then success of treatment depends on eliminating the psychiatric problem. Most of the antipsychotics and lithium lead to sexual problems — supportive counselling becomes necessary.

What are the relational issues?

Chemical dependency leads to poor marital relationships. Therefore, it is important to assess whether the patient has problems with intimacy, communication etc.

Sexual problems in recovery

Impotence

Sexual dysfunction, especially erectile problems (impotence), is one of the frequently noted side effects of chemical dependency. This sexual problem can have an abrupt onset while the individual is using chemicals

in recovery. The typical pattern is loss of erection during intercourse, difficulty in maintaining erection during the foreplay period, inability to get erection and finally sexual avoidance. The exact cause of the problem has not been scientifically established, with both physiological and psychological factors having a bearing on it.

Since sexuality is not readily discussed, the individual has limited sources of information. So during recovery, the patient may firmly believe that he has only two choices — the choice of being a 'potent drunk' or an 'impotent abstainer' and choose the former. For him, the idea of impotence connotes more than a difficulty in getting and maintaining erection; it is perceived as loss of power and masculinity. The person may relapse in an effort to regain potency. This is self defeating and does not solve his sexual problem.

In clinical practice, when confronted with this situation, the first step is to reduce the patient's anxiety by reassurance. It involves providing information and education on sex and erectile functioning. Men think that erection is automatic, and that to be a real man, one should be able to get an erection with any woman, any time. He should be made aware that erection is a complex psycho-physiological response requiring a relaxed mental state and a comfortable, cooperative relationship with the partner.

Most chemical dependents would have learnt to enjoy sex only under the influence of chemicals. They use chemicals to lower inhibitions, reduce anxiety and increase self confidence. In essence, their sexual learning would have been a state dependent upon chemical use. Now they have to relearn to be comfortable and confident in the new sober state. This transition can cause temporary erectile difficulty. If they overreact to this temporary problem, they will become more self conscious and may settle into a chronic performance anxiety resulting in erectile dysfunction. It has to be reemphasised that the transition is temporary, and that going back to chemicals will not solve the problem. However, if the problem persists or worsens for over three months, referral to a sex Counsellor would be appropriate.

Inhibited sexual desire (ISD)

This disorder is defined as persistent and pervasive inhibition of sexual desire. The patient complains of a lack of interest in sex. The reasons for ISD may be both medical and psychological. The more frequent

psychological causes are boredom in the relationship and depression. When the Counsellor plans management, he should first look into the medical reasons. The patient should be sent to a medical professional for a thorough investigation. As an adjunct, psychological counselling will be helpful. The patient should be reassured that ISD is only a temporary phase and with time, definite improvement is possible.

Premature ejaculation

Premature ejaculation is ejaculation occurring before or soon after penetration. It is actually ejaculation occurring before the individual wishes. The management of premature ejaculation can be done by teaching the client the 'squeeze technique', otherwise known as the 'stop and start technique', evolved by Masters & Johnson in 1970. First the couple must be educated about normal sex and all their misinformation should be removed. Then they could be guided to involve themselves in non-demanding but pleasure seeking ways like touching the non-genital and subsequently genital areas of the partner. The emphasis is not on sexual performance but on mutual enhancement of non-orgasmic erotic pleasures. Erection and intercourse are not expected. The couple learn that erection can occur spontaneously when not impaired by pressure and anxiety. The next stage is the most important stage i.e. dispelling the fear of failure because the client anticipates failure as far as ejaculation and orgasm go. The 'squeeze technique' involves the female placing her thumb on the interior surface of the penis and the first and second fingers at the exterior penis surface immediately adjacent to one another on either side of the coronal ridge. Pressure is applied by squeezing steadily the thumb and the two fingers together for three to four seconds. This would immediately result in the loss of urge to ejaculate. He may also lose 10 to 30 percent of his full erection. The wife should allow an interval of 15 to 30 seconds after releasing the applied pressure to the coronal ridge area of the penis and then return to active penile stimulation. Again when full erection is achieved the squeeze technique is reinstituted. Alternating between periods of specifically applied pressure and reconstitution of sexually stimulative techniques, a period of 15 to 20 minutes of sex play may be experienced without a male ejaculatory episode, something unknown to the marital unit in prior sexual performance.

Extra-marital relationships

Having sexual affairs with women (married or unmarried) other than their marriage partner is extra marital sex. This is found to be relatively high among chemical dependents. These affairs would have taken place when the chemical dependent was abusing chemicals, when judgment and reasoning had been poor, or when there had been relationship difficulties with the wife. Society does not permit extra marital relationships. This leads to a value conflict in the chemical dependent who has been having extra marital affairs. Guilt is induced and it is prominent during recovery. Past guilt feelings related to such sexual behaviours have to be dealt with in individual counselling sessions.

PLISSIT model

PLISSIT model is found to be useful in offering sexual counselling to chemical dependents in After-care Centres. PLISSIT is a simplified approach to dealing with sexual problems in chemical dependents. 'PLISSIT' stands for

P — permission giving
LI — limited information
SS — specific suggestions
IT — intensive therapy

Permission giving

In 'permission giving', the Counsellor encourages the client to discuss issues related to his sexual life. The Counsellor should maintain a reassuring climate for the client to talk about intimate issues without hesitation or embarrassment. Also, 'permission giving' establishes an open climate for discussion and sharing of feelings, thoughts, fantasies and behaviours. 'Permission giving' can occur in a treatment unit in two ways.

1. A re-educative session on 'issues related to sex' can be handled by the Counsellor.
2. Literature on 'sexuality and chemicals' can be made available at the After-care Centre library.

These two techniques pave the way for open communication about sex and enable clients to discuss sexual problems without inhibitions.

Limited Information

'Limited information' provides the client with specific factual data directly relevant to his particular sexual concern. The common areas of individual concerns centre on myths about genital size, sexual interest/appetite, responsiveness, orgasmic potential, masturbation, sexual frequency etc. In a treatment unit, 'limited information' should be focused on the chemical dependent's concern for impotence, rapid ejaculation, inhibited sexual desire, many of which occur in his sexual life. This can be done via:

1. A presentation/re-educative session on specific sexual dysfunctions and their relationship with chemical dependency.
2. Structured group therapy sessions on sexual problems.
3. Individual counselling sessions aimed at each client's specific needs.
4. Couple/family counselling sessions dealing with intimacy/sexuality.

Specific suggestions

Collecting data regarding sexual problems is the first step towards developing a therapeutic plan. It is this record which forms the basis for specific suggestions. Suggestions are targeted to each individual client's needs. Some of these suggestions are — 'graded sexual responses', 'sensate focus technique', 'squeeze technique' etc. Information on these skills can be obtained from specific books, as detailed discussion on each of these techniques is beyond the scope of this chapter.

Intensive therapy

Based on the client's sexual history, therapy has to be planned. Some patients may need intensive therapy which may not be available at the After-care Centre. It is essential for the centre to have a list of sex Counsellors in the community who can provide intensive therapy, so that patients can be referred there, if necessary.

Intimacy and recovery

The issues discussed so far have been related to sexual dysfunction. Apart from these, what is more often seen in the recovering chemical

dependents, is fear related to intimacy. These chemical dependents may have normal sexual functioning but may feel inadequate due to reasons such as

- Resentment/anger towards the partner.
- Guilt feelings.
- Lack of communication.
- Lack of trust.
- Ambivalence to marital relationship.

The Counsellor must emphasise that intimacy does not necessarily mean physical intimacy. The client must be encouraged to explore various other ways of being intimate.

Probably the first step in developing intimacy would be to take steps in revealing oneself to another. This could be initiated by the Counsellor in the combined sessions, wherein the couple learns to forgive and forget whatever has happened between them in the past. This understanding helps in developing trust which is primary to building an intimate relationship. Also while sharing they learn to respect each other's feelings.

Marital partners can develop intimacy in different areas -

Intellectual	—	Share ideas and thoughts.
Emotional	—	Communicate feelings.
Aesthetic	—	Appreciate beauty in art, music, literature and environment.
Recreational	—	Share common hobbies.
Physical	—	Express love and affection through physical contact.

Such intimacy can be developed only over a period of time. The couple need not feel anxious or frustrated if they are not able to achieve everything immediately. It is a process, and by constant effort, it can be definitely developed.

Sexual problems are common among chemical dependents. Though they may deny it, it is a major issue which cannot be overlooked. However, proper management of this issue will lead to a satisfying and meaningful marital relationship, which in turn will strengthen recovery.

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13

COPING WITH STRESS

Stress is the reaction of mind and body to change. This definition includes all kinds of changes — pleasant, unpleasant, exciting and boring. Most people think that stress is synonymous with distress. This is not true. Two kinds of stresses have been identified — **Distress** and **Eustress.**

Distress is negative stress. It can be caused by as trivial an event as travelling in a crowded bus, or appearing for an examination, or as serious a matter as a couple's marriage falling apart or a family member facing a serious illness.

There is also a positive kind of stress, called Eustress. It can be felt by an athlete who is geared up for a competition, a father getting his daughter married or a boy getting a seat in a professional college. Thus stress can also be a resource for a person to develop the capacity to meet new challenges.

Stress reaction

Whenever a person is faced with stress (the cause of which can be physical or psychological), there are certain changes that take place in his body and mind. This unique set of changes is called stress reaction. It consists of a complex chain of physical and bio-chemical changes involving the reactions of the nervous system, and the other organs to different chemicals. As a result of this, the body goes on 'full alert'. In response to stress, there is an increase in the production of hormones such as adrenalin. This, along with increased heart rate, oxygen intake and blood flow to the muscles, combine to provide the individual with the strength, energy and clear thinking necessary to give his 'best'. When the challenge has been fully met, all the organs begin to relax, and return to normalcy.

Normally there are three stages through which the entire system tries to respond to a stressful situation.

Stage 1 : The arousal state. The body prepares itself by mobilisation of biochemical resources.

Stage 2 : All available energy mobilised and this energy utilised to cope with the stress.

Stage 3 : The challenge met, the body returns to normalcy. If the challenge is not met, the body reverts to stage 1. (prolonged stress).

Normally people adjust their behaviour to the strains of life, dealing as best as they can. Yet stresses can sometimes pile up and push the individual to a condition which he is unable to manage. This prolonged stress can lead to the development of **stress disorder**. Four distinct stages have been identified in this process.

1. Psychic phase

The excessive trauma makes the individual's Central Nervous System overactive, as a result of which he experiences psychological changes. He becomes irritable, anxious and his sleep is disturbed. He looks worried, and is always thinking of some impending disaster.

2. Psychosomatic phase

If the same situation continues, along with the above stated functional disturbances, certain generalised changes such as hypertension, tremors, palpitation etc. are noticed.

3. Somatic phase

The human body is equipped to deal with stress — but only to a certain level. As the individual's adaptive resources become overworked and exhausted, the body ceases to function smoothly. Different organs become stress targets and symptoms of dysfunction manifest themselves. For example, the person may develop stomach ache, burning sensation in the stomach, etc. if the target organ is the stomach.

4. Organic phase

As arousal continues, the body finds it difficult to adapt to the biochemical changes under increasing strain and pressure. Eventually it breaks down. Exhaustion is expressed through a variety of illnesses. This happens as the lesion settles in the target organ, and the symptoms of the diseases become more pronounced.

The stress-induced disease usually settles in one particular organ depending on the sufferer's hereditary background and environmental factors. These are the target organs, and one can notice a dysfunction of these organs — the stomach (gastritis, peptic ulcer), respiratory system (asthma), Central Nervous System (migraine).

Symptoms of stress

The effects of stress are insidious and the individual often fails to notice them. Signals of stress have been classified below. Early identification helps in effective coping.

Nervous reflexes	Mood changes
Biting nails, clenching fists, clenched jaw, drumming fingers, grinding teeth, hunching shoulders, picking at facial skin, picking at skin around fingernails, tapping feet, touching hair.	Anxiety, depression, frustration, inappropriate anger or hostility, helplessness, hopelessness, impatience, irritability, excessive worrying or excessive day dreaming or fantasising — always wishing he was elsewhere. (Prolonged brooding)
Illnesses	**Behaviour changes**
Backpain, headache, migraine, muscular aches and pains, skin disorders, insomnia (disturbed sleep patterns), digestive disorders, asthma, sexual disorders and hypochondria	Aggression, not eating/eating too much, doing several things at once/leaving jobs undone, emotional outbursts, over reaction, talking too fast or too loud, constant harping on personal failures or short-comings, constant reference to death or suicide, missing appointments and deadlines, confusion, difficulty in getting along with other people

Individuals undergoing stress definitely need to utilise extra resources of help and support. This support should be appropriate and healthy (family, close friends, spouse, counsellors etc.). Some people resort to unhealthy props like alcohol, drugs, cigarettes etc., to get relief.This method is dangerous and should necessarily be avoided. Researchers studying the relationship between stress and chemicals have postulated that chemicals are initially used to reduce tension (to provide relief). However, this in turn, reinforces the individual to continue to see chemicals as an emotional prop. Whenever that individual feels helpless to cope with a stressful situation, his alternative way of coping will be chemicals — inevitably leading him to abuse chemicals.

During recovery, it is very clear that clients should be taught alternative healthy ways to cope with stress. There are various high risk factors that can precipitate a relapse in the client who is abstaining from drugs. Some of them are:-

- Negative Physical States
- Negative Emotional States
- Interpersonal conflicts
- Social pressures

Negative Emotional States	Negative Physical States	Interpersonal Conflicts	Social Pressures
Low self-esteem Guilt, Shame Resentment Hurt feelings Grief, Depression Anxiety	Sleep disturbances Poor health Difficulty in sexual performance	Difficulty in communication Lack of trust of others Others' unwillingness to give responsibilities Suspicion Criticism from others	No job Not accepted by society Pressure from friends to use drugs

If clients lack adequate coping skills, they have to be specifically trained to anticipate stress and taught methods to cope effectively with the same.

Stress reduction

Given below are some guidelines to help the client handle stress during recovery:

Examine oneself

Before one can reduce stress or make it work, one must recognise its signs and identify its sources. The client must learn to monitor his physical and psychological condition. Various signs and symptoms of stress which have been listed out earlier can be given to the client as a checklist.

Ensure physical well-being

The Client should make all efforts to maintain good general health. Regular eating habits with a well balanced diet should be developed. Regular exercises will help the individual to develop optimal health to cope with stress. He should develop regular sleeping habits and take adequate rest. Relaxation techniques also will be useful.

Ventilate feelings

Accumulated stress eats away one's energy and health. One must express how he feels, even if nothing can be done about it. To whom a person ventilates, depends on the level of trust. Clients should be encouraged to join support groups. Support groups like the Alcoholics Anonymous and Narcotics Anonymous help them to ventilate feelings. When a client is under stress, solutions of others provide options for him to mentally review what he has done or what he can do when faced with a stressful situation.

Identify a goal and develop a plan

The level of stress is more when the client does not find a goal or purpose for his life. Helping the client choose short term as well as long term goals, reduces his helplessness. This should be followed by a structured programme for each day, which would help the client work towards his goal. Adequate time for every activity, including recreation should be spelt out.

Procrastination should be avoided as it increases stress. To organise better, clients can be encouraged to establish a routine. A routine will help establish priorities and decrease wasting of time.

To conclude, stress and chemicals are closely related and stress can lead to relapses. Therefore stress has to be effectively managed, and one must learn healthy ways to cope with it.

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14

UNDERSTANDING VALUES

What is a value?

A 'Value' indicates the regard for a quality, or an attitude which, for some reason, is esteemed by the value-holder. A person's norm for what is 'proper' behaviour or a 'good' attitude is based on the way he wishes others to treat or view him. Behaviour norms such as humility, taking responsibility, being helpful, are all based upon the same consideration of how one would like others to treat him. Thus, ethical norms or values are not just arbitrary, man-made rules but stem from an inherent, common regard for one's own interest and comfort. Values are universal. There may be some cultural variations in degree or emphasis, but the basic standards have a certain universality.

Values form an integral part of one's life. They form the thread which connects the colourful beads of experiences to create the garland of life. They actually determine the quality of a person's life. A man is normally known and acknowledged only by his values. (''An honest person;''.... ''A disciplined person;''.... ''He is educated, but does not have integrity''). Values are generally passed on from one generation to another. When children trust and hold their parents in high esteem, they automatically follow and adopt the values upheld by the parents. For example, when parents show respect and courtesy to others, children take them as their role model and even without conscious knowledge they extend courtesy and respect to the people whom they meet. Punctuality and cleanliness are examples of other values which children directly learn from their parents.

'Merely stated' values

These are beliefs which a person claims to hold but never follows. In other words, these are values which are preached but not practised. Sometimes one may not even be conscious that there is a disparity

between what he says and what he does. Such a person will never be able to make others follow or see any value in what he is preaching. They will follow only what he does, and not what he states. For a value to be effective, it is not enough if it is merely 'stated'; it has got to be 'lived'. The alcoholic father tells lots of lies; slyly takes money from the 'Hundi' in the Pooja Room, but does not hesitate to punish his child when he speaks a lie or steals something from the school. The father is not even able to see that it is his own behaviour that has been observed and followed by his child. The child is really confused when he is punished because he does not see anything wrong with stealing or telling lies. Similarly, the mother who shows disrespect to her mother-in-law, is not able to see the absurdity when she gets angry at the defiance of her daughter. The mother may preach and talk a lot about the val ıe of 'respect to elders' but will carry no conviction whatsoever because the child will only see what the mother is **doing** and not what she is **stating.**

Lived values

These are beliefs which an individual upholds and follows. When values are put into action and practised, they develop into a way of life. When beliefs become part of the person, they never change. For such a person, what he thinks and what he does are in perfect harmony with each other. In other words, the knower and the doer are the same. For the expression of a value to become spontaneous, one must see its real value in his personal life. He must recognise the worth of the values. Only then would it be possible for him to implement them in his life. In other words, a value becomes a value for a person only when he sees the benefit of the value. For example, the child who is convinced about the benefits he is going to derive as a result of his education, recognises the value of 'knowledge and education'. He puts in hard work, reads a lot, updates his knowledge, etc.

For a person with lived values, life becomes very simple. No conflicts cloud his mind. He does not have to ever feel guilty, because there is no discrepancy between his thoughts and actions. Such a person also becomes a good role model for his children. Gandhiji is an example of a person with 'lived values.' Gandhiji advocated non-violence and simple living. He also practised non violence and led a simple life.

Assimilated values

In course of time, 'lived' values become a part of the person. The child who sees the mother going to the temple every day, starts doing the same thing without questioning. He may not even be aware of the benefits he is going to derive from the particular value which he has imbibed. "Trust in God" becomes a deep rooted value for this child, and when he grows up, he derives lot of comfort and strength from this value which he has imbibed from his mother without conscious knowledge. As an adult, when he feels the power he gets and the confidence he acquires, he comes to have a well understood, well **assimilated personal value** for "Trust in God".

Any value, when it leads to a sense of 'feeling good', automatically becomes a natural, spontaneous, personal, assimilated value. The conduct mandated by one's personal values, becomes what he does without reflection or thinking. Matters of hygiene are everyday examples of personal assimilated values. Even though one may be quite hungry, he does not consider picking up and eating an apple found in a garbage heap. One does not have a daily debate with himself over whether to brush his teeth or comb his hair. Conforming to these values creates no conflicts whatsoever for him.

Value enrichment

Constant practice enriches values. New experiences and environment provide an opportunity to exhibit the value in all its dimensions — not with mere 'better sameness', but 'with a difference'.

> *The resident physician of an 'Addiction treatment centre' discovered a cyst in the pancreas of an alcoholic. This treatment was beyond the scope of the addiction centre. The doctor's responsibility in such a case was to refer the patient to a specialist in the Government Hospital. The physician made an assessment and felt that if the patient was given a choice, he would neither go to the Government Hospital nor get back to the Addiction treatment centre.*
>
> *He was an extremely poor patient. So the physician put up a case for special funds for the patient's incidental expenses at the Government Hospital. She took the trouble of talking*

personally to the concerned surgeon, She took enormous personal care and kept in touch with his family to ensure that the patient reported back to the Addiction centre for treatment.

As per the job requirement of the doctor, she was not required to do anything more than the following

- *tell the patient about the problem he has*
- *refer him to the Government hospital*
- *leave the choice entirely to him as to what he wants to do.*

In this case, the care and concern shown by the physician takes her well beyond the boundaries of her job specification and enables her to provide wholesome and meaningful treatment to the patient.

Sticking to her terms of reference, she might still have displayed the value of 'care and concern.' But in doing what she did in this instance, she has enriched that value by performing well beyond those 'narrow' frames of reference.

Value enrichment leads to greater job satisfaction and gratification. It provides wholesome meaning to human existence. The person practising enriched values feels happy, contented and successful in life. For such a person, each and every experience contributes towards personal development and enlightenment.

Addiction leading to breakdown of values

Whenever, due to some reason, the behaviour of an individual does not coincide with his values, it leads to conflicts. Such conflicts occur when a person is unable to live up to his values. When there is such a conflict, the person suffers from guilt, self-condemnation, remorse, a feeling of worthlessness, extreme regret etc. This is a common condition among chemical dependents. Drug-related behaviour like violence, aggression, grandiosity, dishonesty, irresponsibility, selfishness etc. become a part of the chemical dependent's life style, even though they could be totally contrary to the values which the person might have previously adhered to.

Ram recalls events which happened during the period when he was taking brown sugar. On a day when he did not have

money for his drug, he decided to somehow get it from his office. He told his boss that his mother was seriously ill and that he needed money for her hospitalisation. His boss gave him Rs. 500 which he took and disappeared. For the next 10 days, he was with his friends at the 'den' and never attended office.

His boss wanted to find out whether something was seriously wrong with his mother. So he sent a couple of his assistants to Ram's house to ensure that she was okay. When they entered, to their shock and surprise, Ram's mother was carrying water from the well. She was looking normal with no indication of anything having gone wrong with her health.

Ram had been dishonest, and he was not even bothered about the fact that he had to face his boss the next day. During the different stages of his dependency, Ram was breaking all the values he had learnt in his childhood.

During the chronic stage of addiction, the chemical dependent does not hesitate to beg, borrow or even steal to maintain his supply of chemicals. He becomes totally self-centred and irresponsible.

Shanmugham almost always came home drunk. Even when he was not drunk, he was highly irritable. His only son had been of late complaining that he had severe stomach ache and was unable to eat. Whenever the child complained of nausea, Shanmugham thrashed the child. The child was getting beaten every time he said he had no appetite. The child was looking sickly, and was unable even to walk.

One week later, the child got up from bed and collapsed. Shanmugham's wife took him to the doctor and she was told that the child's condition was critical and that he needed immediate treatment and hospitalisation. He was in the advanced stage of jaundice. Shanmugham's wife went home; borrowed some money from her friends, and asked Shanmugham to accompany her to the hospital for admission. Shanmugham promised to bring an auto. On his way, he met a few of his 'friends' and decided to go to an arrack shop with

them to 'calm down his nerves'. He started drinking; lost control; spent all his money and reached home at night in an auto. He was too drunk to feel guilty or ashamed over his total irresponsibility and utter selfishness.

During abstinence, he gets exposed to his appalling behaviour and he is shocked to see the way he had broken his values. This leads to an intense inner turmoil, resulting in feelings of extreme guilt and shame. Sometimes he decides to run away from these emotions by resorting to drugs, and again the vicious cycle starts. Until this cycle is broken, recovery from addiction is not possible. He has to give up drugs/drinks, and at the same time, make conscious efforts to improve his behaviour and rebuild the values which he has lost.

Understanding values and living by them

For the chemical dependent, priorities have got to change. Changes take place slowly, through various life experiences, through the influence of people one lives and associates with, the books he reads, the things he observes and so on. Close friends and associates have a significant influence on a person's values and value system.

Following are a few methods which will help the chemical dependent change his old way of life and build a proper value system which will enable him to live in peace. Senior A.A./N.A. members and Counsellors at the After-care Centre can be taken as a role-model by the recovering person. The chemical dependent perceives the 'lived values' of the Counsellor and other peers. The care and concern shown by the Counsellor will reinforce the values of being helpful and loving. He imbibes values of punctuality, trust in God, honesty and compassion.

The environment at the After-care Centre provides an opportunity for the chemical dependent to get back the values he has lost during the various stages of his dependency. He should be made to see the benefit of each value to him. He will make situational choices only when he thinks that such choices will make him feel good.

Nikhil recalls,

"During my 'brown sugar days', I had been almost brutal in my behaviour towards my mother. I had been showing disrespect to her and was unconcerned when she was struggling

to work in spite of her sickness. With a lot of effort, she had saved a small sum of money. Unhesitatingly I stole the money and spent it on drugs. I did not even regret it. There were so many other instances when I had behaved in ways totally unacceptable to me now.

It was only during recovery that I realised the extent of damages I had done. I was shocked to see the level to which I had stooped. At the After-care Centre, I realised the tremendous impact of the values of care, understanding and being helpful to others. I decided I should make amends for my past behaviour by showing genuine love and affection to my mother. I did this in all earnestness. What did I do?

- *I took a loan from my provident fund money and took my mother to a doctor*
- *I admitted her in a hospital and spent the entire month with her*
- *I took efforts to satisfy each and every need of hers*
- *I wrote letters to all the people to whom she wanted to communicate*

When I saw my mother feeling happy, I realised that care and concern shown by me to my mother, has, in turn, given me fulfilment and satisfaction which I never dreamt I would ever experience."

Whenever the recovering person makes an honest attempt to rebuild his values, the Counsellor should encourage him and assist him if necessary, to reinforce the value. The chemical dependent should be made aware that long-term sobriety can be achieved only if he becomes aware of his shortcomings and starts leading a meaningful life, living by values. He will not be able to get back his values without conscious effort. However, with continuous, committed effort, he is sure to get back to living by proper values. In course of time, they will spontaneously express themselves in his life, making it more meaningful, more productive and wholesome.

Additional information

Methods suggested to start living by values

Sometimes patients may find it difficult to name and identify the values they want to follow. Here is a list of values for their reference. It is certainly not a comprehensive list. They can add to it and make it more complete.

Honesty
Care and concern
Responsibility
Discipline
Punctuality
Following family traditions
Spending money wisely
Helpful
Trust in God
Listening
Open mindedness
Hard work
Respect for elders
Giving importance to education
Good health
Alcohol/drug free life
Gratitude
Cleanliness
Patience
Orderliness

After making this list, the Counsellor may ask the patient to list 5 values he wants to follow in the order of his priority. He should separately prioritise 5 values which he expects his children/siblings/peers to follow. After the patient completes both the lists, the Counsellor may see whether his values coincide with the values he wants his children/siblings/peers to follow. If there is a disparity, he should be explained the importance of 'lived values'. He should be made to see the need for him to follow the values he wants his children/siblings/peers to adopt.

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15

COMPULSIVE GAMBLING

Chemical dependents may present themselves with other addictive behaviour patterns also, and of these, gambling is the most common one. This is a problem which needs to be handled in therapy simultaneously with alcohol/drug problem, as gambling too is compulsive in nature and can trigger a relapse in the recovering person. Compulsive gambling is listed as a psychiatric disorder and it assumes alarming proportions since it is progressive in nature.

Gambling has been defined as a progressive impulse disorder in which an individual is chronically and uncontrollably preoccupied with gambling, and with the urge to gamble.

DSM III R calls it 'pathological gambling' and lists nine specific features.

To make a diagnosis of 'pathological gambling', it is essential to identify at least four of the following symptoms:

i) frequent preoccupation with gambling or with obtaining money to gamble.

ii) frequent gambling with larger amounts of money or over a longer period of time than intended.

iii) feeling a need to increase the size or frequency of bets to achieve the desired excitement.

iv) restlessness or irritability if unable to gamble.

v) repeated loss of money through gambling and returning another day to win back losses (''chasing'').

vi) repeated efforts to reduce or stop gambling.

vii) frequent gambling when expected to meet social or occupational obligations.

viii) giving up some important social, occupational, or recreational activity in order to gamble.

ix) continuation of gambling despite inability to pay mounting debts, or despite other significant social, occupational, or legal problems that the person knows to be exacerbated by gambling.

Gamblers basically fall into two categories:

1. A person who gambles.
2. A sick gambler

Who is a 'person who gambles?' He is the occasional bettor who does it for fun and sociability (playing cards during special days like Deepavali, marriages, buying lottery tickets, etc.)

The 'sick gambler's' life is controlled by gambling. His time, efforts and financial situation are determined by the status of his gambling. Usually there is little chance that the compulsive gambler is "spotted" by his friends, associates, colleagues, fellow workers, etc. Sometimes, the nature of the disorder lends itself to privacy and lack of detection.

Compulsive gambling has been defined as a "progressive behavioural disorder". 'Progressive' is the key word. The progression usually goes unnoticed until the behaviour (gambling) has become a disorder (illness). One of the more insidious aspects of the problem is the fact that the gambler doesn't mean to harm anybody. His generous intentions block the reality that gambling is a big-money business, and that in the long run, he cannot win (DENIAL). The sick gambler really believes he will make that one big "win" which will enable him to pay back everybody and also give his family, friends and relatives all that they want. The important issue is that he believes that the big "win" is just around the corner. The sick gambler is so persuasive that his family also believes in his fantasies of success, and this enables him to get deeper into the problem.

The family's role

Typically, a compulsive gambler's wife does not initially recognise the problem. In the beginning, she too enjoys the excitement of the gambling life — the fantasies of winning — the dreams of luxury. But when repeated loss of money affects their standard of living and becomes a point of concern, she wakes up to what is taking place. Later, when she realises that gambling is causing serious financial problems,

she protests, and seeks help. The typical enabling behaviour seen in a chemical dependent's family is seen here also, with the same intensity.

Guidelines to handle compulsive gambling in chemical dependents

For any professional help, a clear history is essential. A history covering all aspects — how it started, its progression, the predominant mode of gambling, damages in several areas — is to be obtained. As discussed earlier, in a gambler, denial may be very high, since there are no obvious symptoms of addiction (especially physical addiction). Therefore, it is essential for the Counsellor to supportively confront the client. For successful recovery, breaking of denial is essential. All the guidelines given in the chapter on 'Handling Denial'* should be kept in mind.

The client should be helped to identify activities to substitute 'gambling time'. The activities can be varied — from hobbies, recreational interests, to more serious work like joining a new course, etc. The essential goal is to learn to handle the 'urge' to gamble during the 'prime time'.

Gamblers Anonymous (GA) is in its infancy in India. GA is again based on the 12 steps of AA, and therefore, recommends two important ideologies:

1. Belief in a Higher Power
2. Living one day at a time

It is also essential to involve the family in therapy and educate them on facts regarding the compulsive traits of the chemical dependent, the need to break the family's enabling behaviour and work out their own recovery plans. Gambling, if not handled properly, will be a major hurdle to sobriety, and therefore, requires prompt attention.

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* Refer "Alcoholism and Drug Dependency - The Professional's Masterguide."

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16

IMPROVING THE QUALITY OF LIFE

Recovery from chemical dependency begins with staying away from drugs totally for life. But abstinence is only the starting point of recovery. Long-term sobriety can be achieved only if the chemical dependent consciously makes improvements in the quality of his life.

What is quality of life?

The answer rests on what is meant by the word 'Life'. What do we associate the word 'Life' with? 'Life' means activity. It may be defined as a series of actions or a series of experiences. Each experience becomes a unit of life just as a brick is the unit of a wall. The strength or weakness of the wall depends on the quality and nature of the bricks constituting it. Similarly, the types of experiences that each one goes through, determine the quality of his life.

Addiction has led to severe damages in several areas of the chemical dependent's life. So during recovery, he has to consciously take steps to set right those damages. Working towards a concrete goal will make a qualitative improvement in his 'new' life and make it purposeful. Following are a few suggestions which will make the chemical dependent's life more meaningful and add to its quality. The therapeutic environment of the After-care Centre will facilitate the patients to implement these in a phased out manner.

Identifying a goal

Finding out a goal and working towards achieving that, will make the life of the recovering person really meaningful. Initially, the chemical dependent, struggling to get over the pain of addiction, may have no other goal except to abstain and 'stay clean'. For a person who is clean and sincere about staying clean, some of the main challenges to recovery have to be identified and short-term goals planned to manage those challenges.

- There may be 'drug craving' which can remain strong for many months following physiological withdrawal and which may even renew itself upon one's discharge from a drug-free environment. Craving may be stimulated by a host of settings and events that a recovering person must gradually learn to handle or avoid altogether. It is very important for him to learn to assert himself and say 'NO' if it is offered.
- There is a need for a new social network. This calls for socialising regularly in ways unfamiliar to him so far.
- There are the adjustments to drug-free activities and satisfactions. These adjustments constitute a learning process, as old forms of fun must be discarded and replaced by new ones.
- While learning new forms of pleasures, the recovering person must also learn to respond safely to physical pain and stress without resorting to drugs.
- There is a need for intimacy in family relationships. This might have been deeply damaged. Family members who were once close will still be available, but may be difficult to approach. Intimacy can be vital but especially problematic for a person whose self-esteem is often fragile.

All these challenges must be managed and therefore, it is very important for the recovering person to have clear cut short-term goals which will help him manage the immediate challenges

But abstinence cannot long remain an end in itself. It must soon become the opportunity to do something more with life, lest all these efforts seem pointless. In short, recovery from addiction can be secure only if the person has found new life goals and has begun to work towards their achievement.

While short-term goals are oriented towards specific recovery needs, the future, however, means wider opportunities. Every patient should be encouraged to identify atleast a few attractive and meaningful possibilities. These goals should necessarily be realistic, achievable and meaningful. If the chemical dependent is able to complete a few short-term goals on the time-frame needed to complete the tasks, he will feel good about himself. This will also give him confidence and help him to undertake more difficult long-term goals. Goals help him find footholds

and paths on the slippery slopes. They shape his energies. They give him hope.

Here is what Naveen, a recovering alcoholic has got to say:

"When I came out of the After-care Centre, I decided to rebuild my workshop which I had totally neglected during my drinking days. Yes! I had to somehow do it. I listed out all the things I had to do towards building it up; met a few people who had initially helped me in my endeavour.

Even they laughed at me. 'Are you really serious or are you joking?' — they had no confidence in me.

Still I was very clear about my goal. I was ready to put in any amount of hard work. It is my workshop. I am rebuilding it..... Yes, I will enjoy the process of doing it. I planned step by step, and in the end, I did achieve my goal! I felt really good about myself. The amount of thrill and pleasure I derived when I completed each step..... Oh! it cannot be expressed through mere words!"

To others, Naveen's goal was unrealistic. They laughed at him. But Naveen had a lot of clarity in his thinking. His sincerity and hard work did pay him dividends. He achieved his goal and was immensely happy.

The goal will definitely differ from person to person. It may be anything — its sole purpose is to add value to life. For one individual, a new professional career may be a viable objective; someone else may recognise meaning in providing support to his children in their studies.... to save money for the daughter's wedding..... no matter what the goal is, real satisfaction is derived once he starts working in a committed manner towards achieving that goal.

However, these goals should be periodically evaluated by people who are interested in the recovery of the chemical dependent. These can be discussed with the family members, the wife, parents, a friend or a Counsellor.

Working towards the goal

Once the person has identified a goal, the next step is to make a daily structured plan which will enable him to proceed towards achieving

that goal. Commitment, sincerity and hard work are the prerequisites. There are no substitutes.

Every day activities should be directed towards achieving that goal. The recovering person should be helped to list out the priorities in his life so that he can set goals according to his priorities. In order to achieve each goal, he will be listing sub-goals or tasks to be executed towards achieving that goal. He should also have a time scale for the completion of every task. At the end of every day, he can make a list, on a paper, of the items to be accomplished the next day. As they are completed, he can cross them off. On a good day, he may find himself crossing off nearly all the items and feel really happy.

Krishnan, a tailor who had been abusing ganja says,

"When I came for treatment, I was in shambles. I had lost all my three shops and had even pawned my last sewing machine.

During my two months' stay at the After-care Centre, I decided on two things

- *I'll not touch ganja again.*
- *I'll get back one of my shops.*

When I talked about this, my relatives ignored me. Some of them made fun of me. I didn't bother. I planned all the things I had to do. I worked under another tailor for a month; earned some money and hired a sewing machine. I carried the machine, walked across to several houses, sat there and stitched for them.

There were moments when I felt really depressed. "Why should I slog like this? Why not smoke ganja again?" Immediately I would stifle such thoughts. No. I'll surely get back my shop. I worked all through the day, saved enough money and bought my own sewing machine.

My family was very happy and helped me in all possible ways. I took a contract with two schools to stitch their students' uniforms. Everyday I noted down my schedule and always delivered the uniforms on the promised date.

This brought me a 'good name' and orders piled up. In one year's time, I got back my first shop. This motivated me to work harder and within two years, I got back all my shops. You will be surprised if I tell you that my third shop was 'opened' by a famous film star."

Working with gusto and enthusiasm

Enjoying the work he is doing, will be a new and delightful experience for the recovering person. However, this calls for a positive change in the attitude of the chemical dependent. All along, he had been seeking happiness and gratification through drugs. Now he would have realised that drug taking is no more a pleasurable experience for him. So he has to replace it by other ways of deriving joy. Are there any changes he has to consciously make towards enjoying life? Ofcourse, yes. The disinterested person should start getting interested in all the activities of life. His depression should be replaced by enthusiasm. All along he might have been dishonest, selfish and unconcerned about others. Now during recovery, he should get involved in and committed to whatever he is doing. Whatever be the nature of work he is performing, if it is done with total involvement, it will surely give him immense satisfaction. Once he is back home, he may be helping his children in their homework; ..... assisting his wife in household chores; ..... cleaning the house; ..... buying vegetables for the family etc. The job per se may be a simple one, but the fact that he has done it to the best of his abilities, will definitely give him satisfaction.

Joseph says:

"Only now when I am off Ganja, do I realise that there are so many little pleasures around me. The early morning with its cool breeze, refreshes me. Today I am able to enjoy each and every dish that my mother prepares for me. I personally go to the market to buy vegetables. I know what my son, wife and mother like. I take special care to buy what each one enjoys... Today I am able to help my son with his homework, and both of us enjoy the experience. Whatever I do, gives me lot of joy and satisfaction."

Exercising the freedom of choice

Unlike animals, man has the right to choose. Animals are governed by their inborn instincts and their urge to survive. For example, a tiger instinctively fulfills the need to nourish its body by eating other animals. It does not and cannot choose to be a vegetarian and start eating grass. But man has an intellect, a thinking faculty, and unlike animals, mere bodily survival does not constitute his life. He not only wants to continue living, but to live in a meaningful way.

Time and again, the chemical dependent should ask himself,

"Have I understood the importance of making choices in my life?"
"Am I aware of the choices given to me or do I lead a life which is governed by impulses?"

He can make the best out of his life, rebuild meaningful relationships, provide financial support for the family, excel in his job, have lots of fun and derive real happiness by giving up only one thing — he has to stop drinking/using drugs totally for life. His powerlessness over chemicals will no more be a handicap for him, provided he takes necessary steps to put back his life in perfect order.

If we go through the careers of people of achievement, we will be firmly convinced that a large number of them succeeded because they started out with handicaps that spurred them on to great endeavour and great rewards. Milton wrote his immortal poetry when he was blind, and the great Beethoven composed everlasting music when he was deaf. Helen Keller's brilliant career was inspired and made possible in spite of her blindness and deafness. Wilma Rudolph till the age of 11 was afflicted with polio, and yet, went onto become an Olympic Gold Medallist in the 100 metres.

The reason behind the success of these great people, is they exercised their freedom of choice in a positive manner. They turned all their handicaps into achievements by looking forward instead of backward. Their positive thoughts released creative energies which made them get so busy that they neither had the time nor the inclination to mourn over what was past and forever gone.

With the help of the staff and other residents, it is possible for the chemical dependent too, to exercise his choice and rebuild his life.

Making meaningful changes

The present status of the chemical dependent is a result of his past life and experiences. However, he need not harp upon the past because it cannot be changed. That he is powerless over chemicals, is a reality which cannot be changed. The actions he had done under the influence of chemicals, cannot be changed. Whatever has happened, has happened. He cannot do anything about them. Instead, he can concentrate on the present — on the things which he can change, which he can repair. He should exercise his self-effort and make meaningful changes in all areas of his life. He can change his attitude towards himself and towards the world. He can strive to make amends to those he had hurt. He can set right the financial damages. He can rebuild meaningful relationships.....and so on. **What** one meets in life, might have been pre-determined, but **how** one meets it, is **self-effort.** The future lies under the control of the recovering person since he has the capacity to change it by regulating his self-effort from now on. The future, therefore, is a continuity of the past, modified by the present. The freedom to modify the effects of the past and create a meaningful future is the result of nothing but self-effort.

Arun, a recovering alcoholic speaks his mind:

"After treatment, I felt terribly guilty...thoroughly ashamed. When I was drinking, I had refused to pay my son's school fees. So he had to discontinue his studies. My God! How cruel had I been! I decided to do something now! What do I do? How do I give him a good future?

I called my son and discussed with him. He was very keen to continue his studies. He said he would join a postal course and finish his schooling without any break.

I immediately enrolled my son in a correspondence course..., started working overtime to pay his tuition fees..., spent a lot of time helping him during his exams.

I made these changes with total commitment; and the result was he became qualified to enter college."

Being aware of personal strengths

The chemical dependent has a normal tendency to belittle his abilities or discount his strengths. He constantly keeps comparing himself with others and feels inadequate. He should be made to understand that the purpose of his life is to discover his potential so that it can be moulded and channelised in such a way that it enables him to discover a meaning for life and make it productive.

> *Prakash recalls, "When I entered the After-care Centre, I was feeling inadequate.... unworthy. After one month, we were asked to play the 'self-esteem' game. Others were asked to point out all the positive qualities they found in me. To my surprise, they identified so many of my personal strengths, which, all along I was not even aware of.*
>
> *Four people said that I was very good at cleaning vessels and washing the clothes. One of them commented that when he was depressed, I was very warm to him and gave him lot of emotional support.*
>
> *I felt extremely happy because for once I realised I was a worthy person."*

In short,

- ★ Recovery is an opportunity to set new goals and new life directions; and working towards worthwhile goals in life is important for keeping recovery strong.
- ★ The recovering person's goals, both short-term and long- term, should be realistic and compatible with the needs of recovery.
- ★ He should make appropriate choices and take necessary steps to put back his life in order.
- ★ He should concentrate on making meaningful changes in his life and focus on setting right all the damages.
- ★ He should develop a strong self-esteem by being aware of his personal strengths.
- ★ No matter who the recovering person is, or where he started from, with commitment, patience, perseverance and hardwork he can definitely improve the quality of his life, and thereby achieve success and satisfaction.

Additional information

A ready-to-use questionnaire for the patients

Addiction might have caused you a lot of suffering. But recovery gives you special wisdom and also a very special opportunity to set a new course for your life. As you define your goals for the near future and beyond, think about the following:

- ★ Are your goals consistent with the needs of recovery, and will they lead you in safe directions?
- ★ Are your day to day activities consistent with your goals?
- ★ Do you have some goals that will be relatively simple to achieve and fun to work on?
- ★ What are the new activities you have taken up? How do you feel after completing them?
- ★ What are the damages that have happened in your life as a result of your addiction? What are the steps you are taking to rectify them? Specify with examples.
- ★ What are your good qualities? How do you exhibit them? Specify with examples.

Although we can't make life go exactly as we plan, we can certainly make plans that help us enjoy life. Make your plans realistic and execute them well. Keep them growing with your own progress. Recognise your strengths — they express who you are and who you can be.

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17

SPIRITUALITY

What is spirituality?

What is the role of spirituality in recovery?

Following are the responses of a few well known people who have specialised in the field of addiction treatment.

Vernon Johnson — Minneapolis, Minnesota:

"A very difficult word. It is not religion, although it expresses itself that way. It is not morality, although it expresses itself that way. It is a quality through which the individual is identified. It is an activating principle which motivates. The way a person looks at himself implies his spirituality. We look in the mirror and see ourselves as being either useless or worthwhile. Chemical dependency destroys spirit. It replaces feelings of self-worth with self-loathing and hate. Recovery means recovery of the spirit."

Linda Smith — Chattanooga, Tennessee:

"It is a process of defining me through the recovery steps of awareness, honesty, surrender, acceptance, gratitude, allowing me to be free from the past,..... finding balance, becoming whole,..... living in the here and now, feeling my feelings, owning responsibilities, making choices, and having serenity. From this process, I find my identity, that is, who I am, and what I am all about".

Dave Mills — Fort Lauderdale, Florida:

"It is a partnership. But I have to hold up my end of the bargain. I can't just lay back and say, 'Okay, God, do it.' The God of my understanding provides opportunity and it is up to me to take advantage of those."

Wayne Kritsberg — Austin, Texas:

"There is a certain improvement in recovery, or a certain quality, for which spirituality is necessary. There is no depth of recovery without

a spiritual anchoring — that is primary. My personal belief is that once a decision is made that there is a God, then everything becomes a manifestation of God — consciousness."

The chemical dependent tried to experience short lived joys, and ended up feeling cheated and betrayed because the hoped for and promised joys of the drug resulted in pain and disaster. This led to an awakening in him. In order to free himself completely from dependency on the drug, a replacement was necessary for him and this is the role of the spiritual.

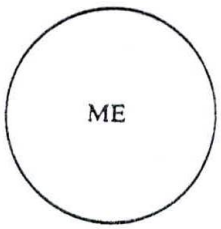
Spirituality is experiencing whatever it is that makes life worth living. It refers to getting in touch with the meaningful and long-lasting values of life while going beyond the superficial. It means waking up to what is really important in life.

Spirituality is a simple way of living. There are four basic movements that recovering people need to make to put their lives on a positive spiritual basis. The first is a movement from fear to trust; the second from self-pity to gratitude; the third from resentment to acceptance; and the fourth, from dishonesty to honesty.

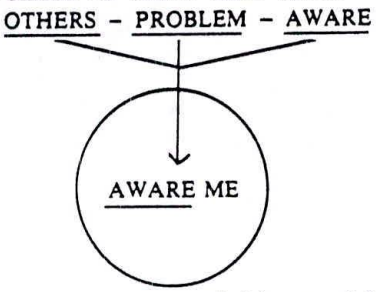
Discovering the meaning of life

Spirituality is really getting at the spirit of life. It is this that enables the recovering person to unlock the secrets of life which contain both suffering and happiness. This happens when looking through into themselves, they discover not only themselves but all that is outside as well. In fact, the power to discover life's secrets lies within the man. Spirituality is the power within man to discover life's meaning. The notion of God or Higher Power is a part of spirituality. The following example will clarify this statement.

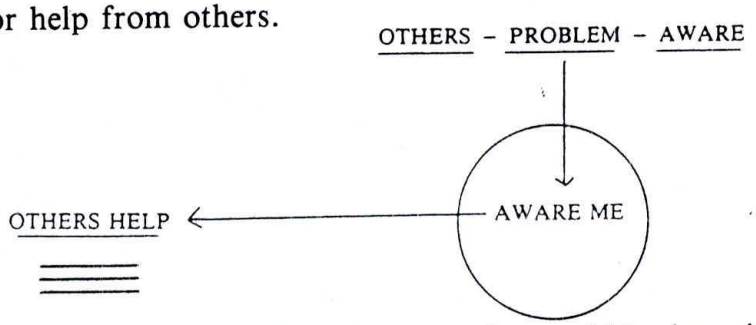
OTHERS — PROBLEM — AWARE



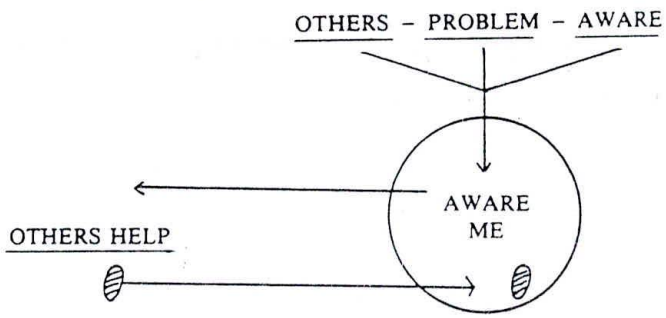
The chemical dependent did not know about his problem first. Who knew about it? — may be his wife, his friend, or his boss. Usually someone outside of himself was aware of the problem before he came to realise. In order to gain awareness, what did he do? He opened up and allowed the awareness to enter into him.



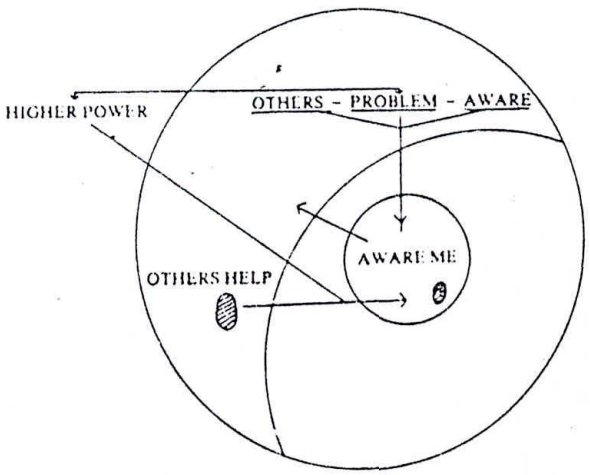
Only then did he become aware of his problem. This awareness, however, was not the solution to his problem. Then where did the solution lie? He opened another door and went out of himself and asked for help from others.



These others indicated for him as to what could be done; in other words, they helped him. But even here, his cooperation was needed. What did he do? He opened still another door and allowed the help to enter into him and become a part of himself.



To the extent the chemical dependent relies only on himself, he can never recover from addiction. To the extent he allows the help to become part of him, he can be sure of recovery. In other words, spirituality enables him to realise that he requires much more than his own resources. He needs outside help. If a person does recover, it is due to his own efforts and he deserves the credit. It is also equally true that he needed all the outside help to recover. The Higher Power works this way.



Rarely does the Higher Power offer direct help. Instead, He works through the outside help influencing the person requesting help. This then is what people mean when they say that their Higher Power is A.A., their Counsellor, their family or their religion. That is the outside influence and help through which the Higher Power comes to the individual.

Let us hear what Sailesh, an alcoholic has got to say.

"I do believe that there is a Power that is greater than me, that has guided and helped me throughout my life. During my drinking days, I had enormous problems. I was really unable to cope. I wanted somebody to help me. I didn't know which way to turn; whom to approach for help; what sort of help I needed — I was confused.

Then the miracle happened. As usual, I came home with a small packet of peanuts to munch along with my drinks. The peanut was packed in the portion of a newspaper.

When I opened the packet, I was thrilled. The piece of paper carried an advertisement of a treatment centre for addiction — the information I longed for. At that point in time, I really felt the presence of the Higher Power in that portion of the newspaper. It was so very valuable to me."

Ravi remarks,

"There were several occasions when I had really felt the presence of the Higher Power. To give you one example, one month after treatment, I stopped taking Antabuse, convincing myself that I will not get tempted at all. I didn't buy the medicine.

One day, when I was walking along the street, I came across an arrack shop and immediately felt a deep craving to have a drink. I was desperate. I found it very difficult to resist. I was too restless. I put my hand in my pocket to take the money to buy one glass of arrack. To my astonishment, what came to my hand was not money, but a tablet of Antabuse. I swallowed the medicine and really felt in my heart of hearts that that was not mere medicine but the Higher Power Itself."

Recognising the need for outside help is basically what Higher Power should imply. To stay with his own resources is to shrink and decay. To reach out for help, is to blossom and grow. To ask for help is not a sign of weakness; on the other hand it requires enormous strength to acknowledge one's limitations in order to develop and grow.

Faith in a Higher Power

Many chemical dependents do feel that at a point in time when they had used up all resources of family, friends and even professionals, there was still one source of help. It is the one that never fails, never gives up, and is always available and willing. When all help failed, they grabbed a rope and hung on.

Every recovering person believes and knows from experience that a Power Greater than Himself can remove his obsession, straighten out his thinking and restore him to sane thought and behaviour. What he calls this **Power**, is a matter of his own choice. Naming It is unimportant.

The important thing is that he believes in It; that he uses It to restore him to health and fitness. Thus faith in a Higher Power is the basic law of recovery. It is always evident in the lives of recovering people.

The chemical dependent need not call this Higher Power, God. He can call this Power as he understands Him. That Power may be a Supreme Force, that designed this vast complex Universe, so far beyond our capacity to understand, of which we are only an insignificant part. We need not understand how the Universe or the Higher Power works. It is like electricity — we do not know what it is, but it is there to use and we use it.

A person walking into a dark room does not worry about understanding electricity. He just looks for the switch and turns on the light. In the same manner, a chemical dependent can turn on the switch of spirituality by simply asking the Higher Power each morning for another day of sobriety and thanking Him at night for another sober day. He should start doing it mechanically even if initially he does not believe in it. In course of time, he will be able to feel the strength and courage he derives from it.

In other words, his understanding starts with blind faith, which open to conviction, grows into "conscious contact with God." A sure way of increasing this help and improving contact with Higher Power, is possible through simple prayers of sincere appreciation. He can start acknowledging the help He has given and be genuine in his thanks for His understanding of the 'problem' and the strength He has given to overcome it.

Prayers of appreciation are good for chemical dependents. They remove egoism and awaken them to life's true values. They act as stabilizers to the restless nature of the chemical dependent.

The serenity prayer

"God grant me the serenity
To accept the things I cannot change..
Courage to change the things I can.
And the wisdom to know the difference."

The recovering person must first accept the fact that he is a chemical dependent. There are certain things he can deal with successfully, but there are certain other things which he just cannot change. The recovering person cannot use mood altering drugs of any nature because that would bring back the negative attitudes and make the positive sense of self worth disappear. He cannot change the situations or happenings of the past when the drugs were in full control and had taken absolute charge. There is no point in clinging to the past and worrying about things which cannot be changed.

There are several things which the recovering person can change. He can correct his past mistakes and make amends to those he had harmed or hurt. He can change his attitude towards himself, his family and friends. He can change his resentful attitudes and replace them with tolerance and forgiveness. He can change his entire personality and start practising honesty, humility, appreciation, forgiveness, promptness in admitting wrongs, making amends and rendering service to others. The recovering person should not waste his time harping on things which cannot be changed, but rather direct his time and energy in helpful, constructive activities where satisfactory results are possible.

Each worthy thought put into practice brings the recovering person a step nearer to the Higher Power. They are the stepping stones over which the person slowly progresses to greater awareness of His presence. They are the means by which he makes a conscious contact with Him. By constant practice, the chemical dependent can gain the priceless reward of contented sobriety.

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18

ASSERTIVENESS TRAINING

'Assertiveness' is the ability to act in harmony with one's values, and self esteem, without hurting others. It is a direct and honest expression of one's feelings towards others, without violating their dignity.

Assertive behaviour, in practice, is a socially appropriate, inter personal behaviour which includes the ability

- To express one's feelings
- To decide how one will act
- To speak up for one's rights when it is appropriate
- To disagree when one thinks it is necessary
- To carry out plans for modifying one's own behaviour
- To help others to change their inappropriate behaviour

As a result of this, one's self-esteem gets enhanced and self confidence gets strengthened.

Thus, when a person conducts himself in an "assertive manner", he is stating positively, assuredly and strongly his own feelings, while at the same time taking into account, others' feelings also.

Each one of us can think and act in three different styles. A close look at these three styles, will clarify what assertiveness really means.

Passive

A passive person fails to stand up for his rights, and does not express his thoughts, feelings and beliefs. In case he does, he expresses them so apologetically, that they are ignored.

Aggressive

An aggressive person stands up for his rights and expresses his thoughts, feelings and beliefs in such a way that other's rights are violated.

An aggressive person hurts others in order to get his way. He ignores others' feelings, needs and opinions. In short, aggressive behaviour is characterised by domination.

Assertive

An assertive person stands up for his rights in ways which do not violate the rights of others. He is clear regarding his own feelings and goals and also knows what he wants to accomplish by asserting himself.

The characteristic traits which dominate each type of personality, are given in the following table

	PASSIVE	AGGRESSIVE	ASSERTIVE
Behaviour	Doesn't stand up for his rights. Puts himself down and is apologetic about his feelings, needs and opinions.	Stands up for his rights but violates others' Puts down others, ignores or dismisses feelings, needs and opinions of others. Expresses himself in rude ways.	Stands up for his own rights in such a way that others rights are not violated Expresses needs, opinions and feelings in direct, honest and appropriate ways.
Attitude	You're okay, I am not okay Thinks that others' needs are more important than his own. Thinks that only others can exercise their rights.	I'm okay, you're not okay Thinks that his needs are always more important than others'. Thinks that others don't have rights Thinks that others don't have anything to contribute.	I'm okay, you're okay Thinks that just as he has his own rights, others also have theirs. Thinks that everyone has something to contribute.

	PASSIVE	AGGRESSIVE	ASSERTIVE
Feelings	Feels helpless, frustrated and angry with himself and resentful towards others.	May feel good temporarily because he has got his way, but is full of remorse, guilt and self-hatred because of hurting others.	Feels good about himself.
Aim	To avoid conflict, pleases others at any cost.	To win at any cost even if it means harm to others.	To maintain self-respect and dignity.

Why do people lack assertiveness?

A major deficit area which has been identified is **LOW SELF-ESTEEM.**

People with low self-esteem typically place three large obstacles between themselves and the goal of assertiveness

- poor communication skills. Inability to stand, look, or talk in a confident manner.
- inability to handle/control their emotions; poor coping skills in stressful situations.
- negative image of themselves. They feel inadequate and experience fear of rejection.

The therapeutic technique by which assertiveness is taught to or enhanced in clientele is called 'assertiveness training'. Therapy goals include an increased ability to express negative feelings (resentment, fear, guilt) and positive feelings (joy, love, appreciation) appropriately.

'Assertiveness training' is also helpful in dealing with issues relating to interpersonal conflicts and problem solving.

Assertiveness will benefit the client in two ways. First, behaving in an assertive way will instil in the client a greater feeling of well being. Secondly the client will be able to achieve significant social rewards (dignity, respect, recognition) and thus obtain more satisfaction from life.

In this, the Counsellor functions as a teacher, with the aim of helping the client understand what is wrong or lacking in his behavioural and communication styles and how to change or improve upon them.

Assertiveness training lays emphasis on two factors

1. Identification of the target behaviour that needs change.
2. Planning with the patient a systematic programme to achieve the result.

Goals of assertiveness training

Assertiveness training aims at teaching the client the following:

★ Everyone has basic rights
★ Each one is responsible for himself and his behaviour
★ It is often appropriate to bring about a change in oneself than in others.
★ When an individual changes his behaviour, others will automatically start responding differently to him.

Techniques of assertiveness training

By far the most commonly used assertiveness training technique is **role play**. This technique requires that the client and the Counsellor act out relevant interpersonal interactions along with other patients. Part of the time the client (who wants to change) plays the role himself, with the Counsellor and other group members assuming the role of some significant person in the client's life such as a parent, employer, or spouse. In carrying out this role, the Counsellor must portray the other person's role in a realistic manner. The following is a summary of the technique of role play as applied to a specific area of interpersonal difficulty.

1. The client enacts the behaviour as he would in his real life.
2. The Counsellor provides specific verbal feedback, stressing positive features and presenting inadequacies in a friendly, non-punitive fashion.
3. The Counsellor models more desirable behaviour, with the client assuming the other person's role when appropriate.

4. The client then attempts the response again.
5. The Counsellor rewards (praise, appreciation) improvement. Steps 3 and 4 are repeated until both the Counsellor and the client are satisfied with their responses, and the client is confident of responding with little or no anxiety in real life.
6. The interaction, if lengthy, should be broken up into small segments and dealt with sequentially. Then the client and Counsellor can run through the entire interaction for the purpose of consolidation.
7. The Counsellor should also monitor the choice of words used by the client and the accompanying expression of feelings.
8. The Counsellor may gradually fade out from modelling assertive responses and have the client assume more and more of the responsibility for generating assertive tactics.

'Assertiveness training' indicates that small changes in one's behavioural pattern may bring about a large and wholesome impact. Assertiveness training is carried out in stages.

In the **first level**, deficits in the following areas can be handled - eye contact, posture, tone of voice etc.

The **second level** involves the basic skills of assertion - ability to say 'no' and 'yes' when one wants to say 'no' and 'yes' respectively; ask for favours and make requests, communicate feelings and thoughts in an open, direct way, and handle criticism.

The **third level** pertains to more complex interactions with others - adaptive behaviour in job situations, ability to form and maintain a social network, achievement of close personal relationships.

Types of assertive responses

An assertive person would display the following emotional/behavioural responses:-

Non-verbal

- Greet others with warmth
- Smile and respond in a friendly manner
- Maintain an adequate, comfortable, erect body posture.

- Establish adequate eye contact. The individual learns to look into the eyes of the person he is talking to.
- Talk in a clear tone so as to be heard by others.
- Use facial expressions that normally go with different emotions.
- Use appropriate natural gestures.

Verbal

Expressing One's Feelings

To express one's personal likes and dislikes explicitly rather than state things in a neutral fashion.

Communicating About Oneself

This does not mean monopolising conversation, but mentioning accomplishments wherever appropriate.

Accepting Compliments

Accepting compliments gracefully rather than disagreeing with and rejecting them.

Practising the use of "I"

Using "I" in situations like admitting a mistake or accepting responsibility.

Disagreeing Appropriately

Not pretending to agree for the sake of maintaining peace.

Asking for Clarification

If someone gives confusing directions, instructions or explanations, the courage to ask that person to restate them more clearly.

Asking Why

If requested to do something that does not seem reasonable, the ability to ask 'why'.

Being Persistent

To restate a legitimate complaint.

Avoiding Justification

The strength to avoid giving excuses, alibis, reasons for one's own or others' behaviour.

Chemical dependency and assertiveness

Clinical and experimental studies on chemical dependency have indicated that interpersonal situations which require assertive responses are stressful for chemical dependents and frequently set the occasion for a relapse. Feelings of social inadequacy or an inability to express emotions can both lead to frustration and serve as potent cues for drug taking. Research has proved that 'social pressures' to drink, and peer pressure to take drugs are the most stressful interpersonal situations faced by the recovering chemical dependent. This finding has stimulated a number of behaviour therapists to advocate that the chemical dependent should be taught to say "NO" effectively. A study by Miller and Eishler (1977) indicates that alcoholics (when sober) showed less ability to express negative feelings such as resentment or irritation and those who were unable to express their negative feelings subsequently consumed alcohol whereas those who did express their negative feelings were able to abstain. Thus a correlation was noted between lack of assertiveness and alcohol consumption.

Typically in the After-care Centre, assertiveness training for a chemical dependent can take the following forms:-

(1) Discussing actual incidents wherein the client had been under tremendous social pressure to consume drugs/alcohol.

(2) Discussing hypothetical situations where the client needs to convince a party otherwise.

After identifying the situation, role play technique can be used to enhance assertiveness.

The situations which can be enacted are:—

- Client attending a party where alcohol is served
- Family members suspecting that the client has taken drugs
- Wife insisting that she will spend on something that the client feels is not of immediate priority
- Boss requesting the client to stay after office hours (overtime) while the client has another important commitment.
- Expressing feelings of anger, anxiety, fear, and depression.

4. **'Don't Say Yes when you want to say No'**, Fensterheim Herbert and Baer Jean, Futura Publications Limited, Great Britain, 1976.

5. **Assertion Therapy: Skill Training or Cognitive Restructuring, Behaviour Therapy**, Linehan, Golfried and Golfried, Vol. 10, 1979, pp 372 - 388.

6. **Assertive Behaviour for Alcoholics, A descriptive analysis, Behaviour Therapy**, Miller Peter and Richard M Eishler, Vol. 8, No. 2, 1977, pp 146 - 149.

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GROUP THERAPY

Group Therapy has been acclaimed over the years as by far the most effective method of treatment for addiction. The gains of group therapy are now well established. Following are a few therapeutic gains that are unique to group therapy.

- Provides an opportunity to share and identify with others who are going through similar problems. Groups help in the development of a sense of belonging.
- The spontaneous sharing of older members, of their progress and the changes they have achieved, instil hope in the new sceptical ones.
- Helps clients understand their own attitudes about chemical dependency and their defences against giving up chemicals by identifying similar attitudes and defences in others.
- Verbalisation of thoughts and feelings, open feed back from others about positive and negative behaviour and being a witness to successful conflict resolution, helps them develop socialisation skills.
- Teaches members interdependence (in contrast to dependence on chemicals) and thus build a better social net-work. This also helps chemical dependents to work through social and emotional isolation.
- Provides a congenial atmosphere to powerfully confront denial, and assess high-risk situations. Members utilise the group as a laboratory for developing new responses and new skills.
- Provides an opportunity to formulate realistic goals and plans.
- Sharing insights, offering suggestions and support, gives an individual the pleasant feeling of helping another. This altruism aids in strengthening self-esteem.

That group therapy can be effective is beyond doubt. The task then for the Counsellor is to maximise the gains within the available time frame.

Following are a few basic guidelines that contribute to effective group therapy sessions.

Size of the group

5 — 10 members in a group is termed by Yalom as the 'Acceptable Range'. When there are less than 5 members, it fails to function as a group; with more, it becomes unwieldy — both making it less effective.

Duration of the group meeting

A minimum of one to one and a half hour is needed for the group to settle down and get to work on an issue. However, if a group stretches beyond 90 minutes, fatigue sets in and diminishing gains are reported.

Frequency of meetings

Five group meetings a week works well at the After-care Centre. On discharge/follow-up, meetings may be held once or twice a week to strengthen changes made and offer support through the recovery process.

Physical environment

A pleasant quiet room, that ensures privacy is a pre-requisite for group therapy meetings. The seats should be similar and placed in a circle conveying that all are equal. Moreover, everybody is visible to the rest of the group; face to face interaction is made possible and non-verbal behaviour can be easily observed.

Rules and limit setting

The Counsellor clearly spells out basic rules like punctuality, regular attendance and staying for the entire session and not leaving midway, not attending under the influence of drugs, at the beginning of the session. The following norms are important and they help members function appropriately:

Confidentiality

Any information gained about another group member in the group therapy setting is to be treated in strict confidence. In short,

"What happens in the group, stays within the group" should be repeatedly stressed.

Listening

Maintaining eye contact, willingness to listen to other person's feelings and words without interrupting, are important. Interruptions are not to be made unless

- the other is repetitious.
- the other is rambling without focussing on issues relevant to the topic of discussion.
- the listener has not understood and wishes to clarify his thoughts.

Using 'I' Statements

'We' and 'They' statements lead to superficial sharing on generalised issues. 'You' statements usually turn into critical, judgemental ones. 'I' statements, on the other hand, help him speak only for himself and own responsibility for his feelings, thoughts and behaviour. (Example: "I feel ashamed. I have hurt my parents").

Open, Honest, Spontaneous sharing

Group therapy offers an unique opportunity for handling issues. It should be emphasised that to maximise gains, wholehearted participation of the group is essential. Each member needs to remember that "the more he puts into a group, the more he will benefit from the experience".

All participants are considered equal, irrespective of their drinking/drug taking status, number of days they have stayed at the Centre, or nature of the damages. The Counsellor, as a facilitator of the group, need not share any details regarding himself.

Feedback

Guidelines for giving feedback

Feed back is an essential component of group therapy.

The following are a few guidelines to be discussed with the clients prior to entry into the group:

★ To talk about behaviour one can see.
It should be specific and relevant. "I notice that you are late by 5-10 minutes everyday. So we are unable to start the group meeting on time."

★ Feed back should be given caringly and not by hurting or attacking another member. No judgemental statements should be made.

"I can see your problem. You are working in a bar, and you have no access to A. A. meetings also."

★ Members should avoid sarcasm and condescending remarks while giving a feed back. No advice is to be given - only responses.

"You want to repay debts to the tune of One lakh in 6 months? You must be joking." - Sarcastic remark.

"Listen to me. You cannot handle this. You better ask your wife." - Advice.

"Let us plan out various methods and see how best it can be worked out." — Proper response.

★ Members should be encouraged to share positive feed back also.

"I am touched by your honest sharing."

Guidelines for receiving feedback

★ Members should spontaneously ask for feed back and openly receive it.

★ Excuses should not be given. Members should avoid defensiveness.

★ Members should learn to acknowledge the value of feed back and express appreciation.

"I am glad you have helped me see the positive qualities of my brother."

★ Members should think and build upon the feed back given. They should view feed back as a continuing exploration.

The process of group therapy

Classically the group process can be divided into three phases. The early phase is the beginning of the group, particularly the first few meetings. The middle phase is the substance of the group, with the clients coming

together, interacting, sharing, growing and changing in the Counsellor's presence. The last phase is when the client completes the programme and leaves the group.

The first meeting

Group members are usually very anxious over their first meeting. As in any relationship, introductions are needed. The Counsellor initiates the process by introducing himself, outlining the purpose of the group, and soliciting introductions from the clients. This can be done in several ways, of which the following is one example:

> "I am glad that every one of you could make it. Let's get started. As you know my name is ..... I want to tell you why we are here and what we will be doing in these meetings. Some of you know each other and others do not. One thing that every one has in common is being dependent on alcohol or drugs. This is going to be a time to get to know each other, learn about problems each one is facing, and find new ways to deal with them. At times we will talk about issues which may be sensitive like feeling lonely, depressed, problems at home etc. Here you will discover that you are not alone with these feelings and when you start sharing you will definitely feel less painful. Members here will help you minimise your pain."

The introduction sets the tone for the group. In the above example we find the following messages:

1) A statement of the purpose of the group
2) Identification of commonality. This aids in developing unity in the group.
3) Disclosure that sensitive issues will be explored. It is vital that clients know that such topics will be discussed.
4) Often they are overwhelmed by their problems and are disillusioned that no alternatives exist. Group gives them the much needed hope.

Introduction of clients can be done in many ways. When the suggestion is open ended that is: "Let's say our name. Talk something about ourselves," the response may be either anxiety -ridden silence, or names

rattled off in a rapid fashion with no mention of personal data. Introductions are the chemical dependent's first step towards self disclosure. They can be in a state of panic and can have a lot of anxiety. To get over this initial barrier, the following methods may be followed. First the group can be divided into pairs and each client asked to introduce himself to his partner. After this initial contact, they could come back, form a group and introduce the person each one met. This exercise helps the client take off direct focus on self. The second method of approach is to request senior members to introduce themselves first, thereby setting a role model for the new comers. After the introduction, the next step is to spell out group guidelines. These group guidelines have been discussed in the earlier part of the chapter.

Extensive clinical observations show how the group evolves and moves through three stages of growth. In general, a successful group will flow through them. While at times, it may regress to the previous stage, it will eventually move into the later stages.

Each stage is characterised by its own set of feelings and behaviour. Being familiar with these, will help the Counsellor identify which stage the group is in, so that he can aid its moving successfully through its developmental stages.

Stages in group therapy

First Stage: Formative Stage

Hesitant participation with random spurts of energy mark this stage. The participants look at each other with caution, find similarities and differences and attempt to establish the universality of the problem of addiction.

Not sure of how the group will progress, participants display dependency on the Counsellor. Communication is limited to superficial issues, stereotyped and directed more to the Counsellor than to other members. They frequently look to the Counsellor for approval and appreciation.

Here the Counsellor should encourage members to relate to the group. By repeatedly calling attention to the need for 'I' messages and descriptive rather than judgemental statements, the Counsellor sets the stage for smooth progress.

The therapeutic benefits which the client experiences in the early phase are —

★ Anxiety is reduced.

★ Clients establish relationships which remove loneliness and isolation.

In the early stage, sharing is more on structural details rather than feelings. Members talk about their expectations, about what they want to achieve during their stay at the After-care Centre, etc. After the initial verbalisation, they start sharing about their addiction-related damages.

Middle Stage

As the group completes its initial tasks, it moves into relating — the heart and soul of group therapy. Initially, the Counsellor will have to actively facilitate sharing, with clear focus on specific issues. The most important therapeutic task in the middle phase is the handling of defences. Defences will be high, and nurturing intervention in the form of support from the Counsellor and the group is necessary in order to break the patterns. The predominant form of defence used is denial. There are atleast two levels of denial in a chemical dependent. First is the denial of the magnitude of the drinking/drug taking problem. Once the initial denial has been overcome, a second form of denial is encountered — the denial of the need to change. This is seen more commonly in the After-care Centre. Both these forms of denial can be handled in the therapy group.

A general approach to handle denial is direct confrontation. Confrontation will be successful only if the patient is well integrated into the therapy group and has made a strong emotional investment in the group process. Confrontation is most useful when spoken with concern and accompanied by examples of the confronted behaviour. Confrontation should be descriptive, focussing on what one has observed in the person. It should be based on specific facts and not a generalised comment, advice or discussions about something which has not been witnessed by the confronter. Confrontation is best accomplished by other members of the group.

The other therapeutic task of group therapy in the middle phase is motivation. This should be an issue of concern throughout and must

be built progressively. Initially motivation is built by focussing on damages, thereby, giving insight to the client on the need to change. Subsequently motivation is strengthened by focussing on the positive changes each individual has achieved. This leads to a hope among group members that it is possible to lead a drug-free life.

Recognition and identification of feelings is another task here. Now the clients will feel comfortable and will be able to identify their negative and positive feelings. An understanding of the fact that addiction is a disease helps them to be able to talk/share about their feelings of guilt, shame and hurt. Also members learn to respond openly to others' feedback, and spontaneously report their feelings without hiding. Chemical dependents discover that it is more helpful to be open than to be right.

The more common negative emotional states like guilt, resentment, low frustration tolerance, shame, fear and anxiety are also dealt with. During the 'group process', healing also takes place.

The Counsellor's main task here lies in being alert to changes in the tempo of the group. The Counsellor should be adept in making significant interventions in case they lose the focus. He should help them focus on issues, bring conflicts to the fore-front and deal with them appropriately.

Towards the latter part of the second stage, the group weaves its way through conflicts with little help from the Counsellor. As the group progresses, they slowly take responsibility for decision making. The Counsellor makes conscious efforts to this end by refusing to answer questions and encourages group participation in views expressed and decisions made. The group thus learns to look for resources and directions from within itself. The group's attitude turns into one of support and understanding for each other. This is eventually followed by a stage of encouragement, appreciation, closeness and intimacy. The therapeutic benefits of this stage are

- ★ Open sharing and ventilation of feelings are made possible.
- ★ Defences are handled in the group itself by the group members.
- ★ Dependence on the Counsellor is replaced by dependence on other group members.

Third Stage

The stage is now set for bringing in the most productive and satisfying phase of the process. Members find it comfortable to express all feelings and take responsibility for what they wish to achieve in the group. Opposing view points are no longer threatening, and conflicts are resolved constructively. Participation is at its best. Significant issues are discussed, feedback received well and tasks get done at a rapid pace.

Sometimes groups fail to get here developmentally especially when conflicts are seen as negative factors. The Counsellor's task will be to stay with the group in the second stage, work through conflicts and help them reach this stage where members feel their dependence as well as their independence. They are able to see their similarities and differences, disagree at times and still feel comfortable.

The Counsellor's intervention helps sharpen focus on emerging issues and provides useful input to handle complex issues. The group may have been revisiting the same problem areas as in the previous stage but they are now viewed from a different perspective. The Counsellor stays tuned to the tempo of the group guarding against stagnation on one issue. During this stage the Counsellor consciously gets ready to bring the group to the stage of completion. The major issues to be focussed on are relapse prevention and recovery plans.

The therapeutic benefits of this stage are

★ Complicated issues are openly discussed and conflicts resolved.

★ Motivation to continue sobriety becomes their priority.

★ Members feel the significance of independence and interdependence. Understand the importance of A.A./N.A. and After-care services to maintain abstinence.

The Resolution Stage

When the group draws closer to completion or when a few members prepare to leave the group, the situation may be anxiety – provoking for all. To the members who are leaving, having to make do without the group's support and encouragement can be unsettling. The rest of the group may also feel bad because they would miss the contribution

of the older members. Now the Counsellor can give them reassurance and encourage the members who are leaving, to make frequent visits to the Centre.

Role of the Counsellor

The secret of making group therapy a powerful source for change is an art and a skill. Here as in a counselling relationship, the basic personality of the Counsellor, his professional training and experience can make a world of difference. The Counsellor has to maintain a relationship characterised by warmth, empathy, concern, acceptance and genuineness. An effective Counsellor will be sensitive and flexible to the needs of the group and flow with it, all the while making valuable interventions.

★ Helping members belong

The group therapy situation may be stressful for the new comer. The members are strangers to each other and look to the Counsellor as the unifying force. By using this 'special member' status, the Counsellor goes on to create one physical entity — "a group", from a collection of members with different experiences and problems.

Being supportive, accepting and sensitive to all members and displaying this through appropriate verbal and non-verbal behaviour, the Counsellor can create a sense of "oneness" or "togetherness".

Late coming, absenteeism, sub-grouping (two or three members carrying on interactions while actively excluding others) and 'scape goating' (majority of the group making one member the target of their negative feelings) threaten cohesiveness. The Counsellor should act early and decisively to counteract these forces.

★ Encouraging 'Feeling Level' Interactions

Feelings of shame, guilt, resentment and fear are the predominant negative emotions. Being able to talk about them in a supportive, caring environment to people who have actually experienced them, is what makes group therapy effective. Handling anger and resentment means getting to grips with the underlying true feelings.

Members who are eloquent, may find it easy to share on a superficial level. By encouraging and emphasising 'feeling level' statements, the Counsellor can help them get in touch with their negative feelings which they try to run away from. Separating thoughts from feelings and labelling feelings, helps them explore further and deal with them better. This exercise stands them in good stead in their future communication patterns and problem solving efforts.

★ Facilitating growth

The Counsellor should never forget that his involvement is of prime importance in shaping the group norms. Too exacting behaviour or being too passive can both inhibit members. He needs to play his role with confidence and poise.

Basic rules that are set at the start of the group process may sometimes need further strengthening. The Counsellor can draw attention to the norms through statements, observations, questions and display of appropriate non-verbal behaviour. For example, to encourage member to member communication, the following methods can be used:

- Asking for the other members' reactions
- Refusing to answer questions directly

Nodding, smiling, good attending behaviour and verbal reinforcements help shape positive behaviour. The Counsellor choosing not to react to low tone conversations, late coming etc. will be noticed by members of the group. Not attending to these can even be seen as non-caring. Unhealthy practices like frequent interruptions or excessive criticism can grow on quickly and it is the Counsellor's responsibility to guard against them.

The Counsellor should encourage feed back. When a member is criticised or confronted, caring questions like, "How do you feel about what was just said?", helps that member respond. When many suggestions or comments have been made in response to one member's sharing, asking him "What did you find most helpful? How did you feel to receive so much?", helps members give appropriate feed back.

The Counsellor is a 'model setting participant' in many ways. Displaying good attending behaviour is quickly copied by the members. By giving support and encouragement, the Counsellor invites members to follow suit. The Counsellor's handling of conflicts by permitting expression of negative feelings and working through them rather than suppressing them, helps members learn to do the same even in real life situations.

★ Recognising the Group's Power

The primary therapeutic agent in a group is always the interaction between the members and not the Counsellor. An effective Counsellor thus recognises that the group's power is more than his own and makes the group assume responsibility to make the interactions. If the Counsellor takes the responsibility, the members would sit back and wait for the Counsellor to make the interventions as if watching a movie.

The Counsellor needs to resist the urge to quickly intervene with the right answers, and should wait for a discussion to follow and allow it to slowly steer to a conclusion. The group values the decisions that they arrive at and does not look for quickfix answers from the Counsellor even if the solutions are just as, if not more effective.

Recording

The progress or lack of it among each member in the group and the Counsellor's impressions need to be recorded. This will help the treatment professional to see clearly the level of progress and plan further directions of progress. In case a different Counsellor takes over, he will be able to

- assess the progress of each member
- set specific goals for each one
- identify and help him plan to deal with negative factors so that they don't grow stronger and interfere with the recovery process
- use these facts to give appropriate feedback to members.

Recording is thus extremely useful and clearly necessary. But for the 'time-pressed' Counsellor, if recording needs a lot of time, it can become stressful and poor compliance will result. To prevent this, recording should be structured, and carefully structured recording will not take more than 10 minutes.

If 5 sessions are held in a week, a weekly recording will suffice. If the session is once a week, recording can be done immediately. Group therapy initiated changes, may continue in-between these sessions also. Recording helps the Counsellor keep tabs on the issues discussed and maintain continuity between sessions.

The ultimate goal of group therapy is to aid self understanding and initiate changes to the maximum level possible in each and every member of the group. Three factors contribute to this outcome.

1. The skill of the Counsellor.
2. The openness of the members who constitute the group.
3. The (genuine) interaction between the members.

Therefore, the skill of the Counsellor needs to be sharpened periodically through frequent self-assessment, clinical reviews with peers, openness to new techniques and readiness to explore in directions suggested by group therapy research studies. The Counsellor has some control over the second factor also in the sense that through a display of supportive care and concern, he can facilitate the group to become open and honest in their sharing. This will lead to genuine 'feeling level' interaction and conflict resolutions. To put it plainly, the Counsellor, even though a catalyst, is the key player and his skill is of prime importance.

Additional information

Problems in group therapy

While conducting group meetings, the Counsellor may encounter certain problems with the patients. Some of the problems posed by patients and methods to deal with them are listed below.

Monopolist

He talks incessantly, interrupts frequently and attempts to be the centre of attention. Ordering him point blank to stay quiet can hurt him and also frighten away other members. On the other hand, if left unchecked, others will become bored, react negatively leading him to sulk and withdraw.

His tendency to hold the stage is often an attempt to keep to the superficial level and prevent others from getting to the real issues. He thus fails to grow in the group.

The monopolist can be handled at both the group and individual levels. The Counsellor can tactfully call for responses from other group members while desisting from discounting the monopolist. By highlighting the need for their participation, the other group members can be made responsible for the manner in which the group is progressing.

The monopolist often continues his unwelcome behaviour unaware of the negative feelings of others towards him. Helping him become aware of this is important. Saying, "Let us now check out on how the group is feeling", can help him get feedback. Summing up the monopolist's sharing can lend focus to his utterances. This, followed by others' feedback, can also help. Repeated, gentle interventions and feedback will be useful in tackling this difficult member who intends to monopolise the group.

Patient who has difficulty in expressing emotions or feelings

He seems isolated, emotionally blocked and acts as if nothing affects him. He is in the group and yet far removed from it — he may go on minimising others' feelings or dismiss them as insignificant.

Helping this patient get in touch with his feelings and verbalising them needs to be done.

Frequently such a person's non-verbal behaviour betrays his feelings. The Counsellor has to call attention to this and ask for his feedback. For example, "I saw you lean forward and show concern when he talked about his loss of job. Would you like to share?"

Encouraging him to give feedback when a member shares something significant, with emphasis on feelings can also help.

Silent Patient

He willingly stays a passive spectator to the group's proceedings. His silence may arise from

- his discomfort in talking about himself in a group.
- his anxiety that if he shares a little, others will force him to share more — more than what he wants to.
- his fear that if he starts talking he may cry or breakdown letting everyone see how shattered his life is.

Some information about the patient's history can help the Counsellor initiate him and make him open up. Even the 'silent'; patient is never 'silent'; his non-verbal behaviour speaks for him. The Counsellor needs to be sensitive to this — note when and what topics interest him; which ones make him tense, amused, and bring them to his notice and ask for responses.

Some prodding and questioning of gradually increasing depth is useful. When the patient does share a little, he needs to be encouraged and appreciated. The Counsellor can get the silent patient to commit himself by saying, 'You shared when questioned today. Did you feel pressurised?' When the patient says 'No' as he usually will, the Counsellor can settle the issue saying, 'I am happy about that. We can then continue doing this in later sessions too. Isn't it?'

An individual session can help in making him comfortable in the group. He should be helped to understand the need for sharing and guided to plan for sharing non-threatening areas.

One who believes he is always right

He advises and gives solutions to all the members and sees his ideas as being the most ideal. He feels an impelling need to be seen as being 'right' all the time. This behaviour is more enhanced if he is older, richer or more educated than the rest of the group. His 'air of superiority' leads others to be hostile towards him as the group progresses. The underlying message in his sharing, frequently is to stress 'how well I have succeeded in spite of problems'. He is unable to lower his facade and get help.

With this patient, surprisingly, the key issue is shame, hurt and a low self-esteem. The common theme in his sharing will be, 'I did so many things right and yet received no recognition'.

The Counsellor needs to make special attempts to help him recognise and verbalise the shame and hurt in his relationships. The other members will take the cue and build on this. This focus moreover helps others to be supportive rather than get irritated by this patient.

Boring Patient

His sharing is usually superficial and repetitious, delivered in a flat monotone. He never 'opens up' his feelings for fear of being rejected.

When this patient launches off on his insipid oft heard statements, group members usually betray boredom by yawning. They also display other behaviour patterns that indicate restlessness.

At some point, members will tell the patient that he repeats the same issues and that his contribution is not sufficient. When this happens, the Counsellor should intervene and ask him to focus on other relevant issues.

Help-rejecting complainer

He has a list of things going wrong (including the poor progress of the group) and will present problems as if his is the biggest of all. He frequently asks for suggestions but does not make use of them. Even when he implements them and finds them useful, he will not acknowledge it. This patient's constant complaints may reduce the faith and hope of the group and weaken cohesiveness.

The Counsellor should guard against becoming resentful of this patient because this is what the patient wishes to happen. He can then use this to 'revalidate' his self-pity and prove to himself that nobody understands or helps him.

The Counsellor should consciously refrain from offering solutions for they will be rejected. The Counsellor should help members see the 'yes — but' approach of the patient to suggestions made. The members thus take over and help him see his 'self-defeating behaviour'.

The Questioner

He frequently asks questions and raises doubts often with a false air of high motivation to get more attention. Questions when excessive can draw the Counsellor off focus and also lead the members to intellectualise on issues.

When not related to the topic of discussion, the Counsellor can say, "I am afraid that by answering this question, we will side track from the present issue. I will be happy to discuss this with you after the group".

The Counsellor needs to be sensitive to genuine requests for information and clarification. When meeting this need, answers are to be kept short followed by a return to topics of discussion.

Patients attending under the influence of chemicals

Patients who have been discharged from the After-care Centre should be encouraged to come for follow-up regularly. During these follow-up visits, clients may participate in group therapy sessions. Involving clients who come on an out-patient basis may spark a few problems in the group. These problems have to be handled.

Primarily these problems revolve around relapses. The four types of behaviour discussed below reflect resistance to treatment and must be dealt with assertively by the group.

Behaviour	Methods to deal with it
Coming to the group intoxicated.	Member should be asked to leave and to return in a condition appropriate for participation. After the member leaves, other group members should be encouraged to share their feelings. When patient returns abstinent for next session, other group members should be asked to share their feelings and discuss what should be done.
Drinking but refusing to acknowledge it.	Technique of confrontation with specific data can be used. Remind the group contract of total abstinence and sharing openly about occurrence of relapses. If drinking/drug taking behaviour continues and is not discussed, client may be asked to leave. The group members discuss their feelings subsequently.
Drinking and talking about it with no intention of stopping or Continued drinking while verbally endorsing group norm.	Members to be asked to discuss their feelings about violation of group norms. Establish contingency contract for the relapsed patient. Group discusses specific requirement that client will have to adhere to (taking antabuse daily under supervision, going to 3-5 A.A. meetings, calling on the staff at the treatment centre everyday) to maintain his group participation.

Behaviour	Methods to deal with it
Repeatedly coming under the influence of chemicals and refusing to leave the group.	The group should not allow this to continue indefinitely. The group should assume responsibility for setting limits and if necessary remove him from the group. The group should be made to understand that the decision is based on current behaviour and that the door remains open for further participation at a later time.

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20

THE ROLE OF THE COUNSELLOR AND COUNSELLING TECHNIQUES

Individual Counselling aims at enabling the client to learn and pursue realistic and satisfying solutions to his problems including those related to his chemical abuse. In order to make individual counselling effective, the therapist has to understand the client as an individual, the influences which have affected him, his perception of self and others, so that he can help the client realise how those forces have led to unhealthy ways of coping. This understanding at the feeling level rather than at the cognitive level, will enable him to cope with life more satisfactorily. The purpose is to help the client in making decisions about his life and enable him understand the need to take responsibility for the consequences.

Qualities necessary for a Counsellor

★ Ability to listen	Absolutely essential. Listening is much more than hearing. It involves intuitive perception, watching for cues other than those conveyed through words (tone of voice, gestures, posture) and understanding the messages which the client is trying to convey, over emphasise or avoid.
★ Empathy	Ability to sense the client's private world "as if" it were the Counsellor's own, but without losing the "as if" quality. Empathy does not imply agreeing to the client's views of things; also it does not allow for any judgement on the part of the Counsellor. He neither agrees nor disagrees; just understands and appreciates the view.
★ Non-judgemental	Being open to and aware of the other person's rights. Such an unbiased involvement is essential to a constructive approach to the client's problem.

★ Genuineness	The Counsellor's sincere interest in the care and well-being of the client, which, in turn, results in his expressions always truly reflecting his thoughts and feelings.
★ Patience	To tolerate slow or no progress in the client.
★ Flexibility	The Counsellor should be able to adapt his role and pace according to the client's needs and capacities. Rigidity in roles and approaches may provide comfort for the Counsellor, but often does little for the client. The Counsellor should be a sympathetic friend, a leader, a negotiator or an educator and able to move between these roles.
★ Emotional maturity	The Counsellor should be able to maintain a balance and not get unduly swayed.
★ To be in command	Once assessment is made and counselling has started, the client should be able to have a person who guides him away from trivialities or irrelevancies. The Counsellor who allows himself to be manipulated without knowing it, will not command respect from the client.

Therapeutic communication skills used in counselling

The outcome of the meeting between the Counsellor and the client will depend a great deal on how free the client feels to entrust the Counsellor with his genuine feelings including information which he may feel is very private and personal and which he is reluctant to share. This can be achieved by the use of certain communication skills which create an atmosphere of support for the client and the process.

Attending

Attending is fundamental to the use of all other counselling skills. It implies a concern by the Counsellor with all aspects of the client's communication. It includes listening to the verbal content and observing the non-verbal cues and then communicating back to the client that the Counsellor is paying attention.

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Guidelines for effective attending are

- to communicate listening through eye contact and facial expression
- to physically relax and lean forward occasionally, using natural hand and arm movements
- to verbally "follow" the client, using a variety of brief encouragements such as "um-hm", "yes", or repeating key words.

In attending, the Counsellor's goal is to listen effectively, to observe the client, and to communicate his interest and attentiveness. The skill of attending is the foundation on which all other skills are built.

Processing

This includes the Counsellor's ability in mentally cataloguing data, including the client's beliefs, knowledge, attitudes and expectations, and thereafter categorising factors influencing the client's judgement and performance.

Probing

Probing is the Counsellor's use of a question or statement to direct the client's attention inward to explore his situation in greater depth. A probing question should be open-ended which requires more than a one-word answer ("yes or no") from the client. Probing helps to focus the client's attention on a feeling or content area. It may encourage the client to elaborate, clarify or illustrate what he has been saying. It sometimes enhances the client's awareness and understanding of his situation and feelings. It directs the client's attention to areas the Counsellor thinks need attention.

> *Client — "I had always been a good worker. I even received an award for excellence four years back. But the last two years..... My God! So much of problems! Lots of problems for me in the office during the past two years."*
>
> *Counsellor — "For the past two years you have been having problems. What do you see as the reason behind these problems?"*

The Counsellor should use his judgement to identify the subject or feelings touched by the client that need further exploration. It is

important that the Counsellor uses 'probing' only after 'attending' to the client. By listening to and observing the client, the Counsellor may identify areas that either seem unresolved or need further development.

Paraphrasing

Paraphrasing is a response that restates the content of the client's previous statement. It concentrates primarily on the words spoken, the content which refers to events, people and things. In paraphrasing, the Counsellor reflects to the client the verbal essence of his last comment or last few comments. More often, paraphrasing is using words that are similar to the client's, but fewer in number.

'Paraphrasing' can be an indicator to the client, of the Counsellor's accurate verbal following. It sharpens the client's meaning to have his words rephrased more concisely and often leads him to expand his discussion on the same subject. It can spotlight an issue, thus offering a direction for the client's subsequent remarks.

> *Client — "My boss constantly irritates me. He 'picks on me' for no reason at all. He is all powerful and he can even 'sack' me. I don't know what I can do if he does that."*
>
> *Counsellor — "You are having problems in getting along with your boss. You seem to be worried that you may lose your job."*

Paraphrasing enables the Counsellor to verify his perceptions of the verbal content of the client's statements.

Reflection of Feelings

'Reflection of feelings' is the Counsellor expressing the essence of the client's feelings, either stated or implied. Unlike in 'Paraphrasing', the focus is primarily on the emotional element of the client's communication. The Counsellor tries to perceive the emotional state of the client and feedback a response that demonstrates his understanding of the client's state. 'Reflection of feelings' is an empathetic response to the emotional state or condition of the client.

It conveys to the client that the Counsellor understands what he is experiencing and feeling. This empathy reinforces the client's willingness

to express his feelings more openly. It gives the client an opportunity to recognise and accept his feelings. It also verifies the Counsellor's perception of what the client is feeling. It allows the Counsellor to check with the client whether he is accurately reflecting what the client is experiencing.

> *Client — "I don't feel like going home at all. When I come home for the week-end from the After-care Centre, my house is in a mess. The kids are dirty and my wife constantly nags and complains. She doesn't even prepare good food; doesn't do her duties. That makes me angry."*
>
> *Counsellor — "You are not satisfied with the way she is running the house. That irritates you."*

Through reflection of feelings, problem areas can be identified without the client feeling pushed. It also helps the client understand that feelings cause certain types of behaviour.

Summarizing

Summarizing is the tying together by the Counsellor of the main points discussed in a counselling session. Summarizing can focus on both feelings and content and is appropriate after discussion of a particular topic within the session or as a review at the end of the session of the principal issues discussed. In either case, the summary should be brief, to the point, and without new or added meanings.

> *Counsellor — "We have talked about two issues now. You feel you have hurt your parents and given them lots of problems. You want to do something about this. The other issue is related to your work. You feel you have been blaming your bosses all along for losing quite a few jobs. Now you understand that drugs had been the cause."*

Summarizing clarifies the client's meaning by having his scattered thoughts and feelings put together. It can terminate a session in a logical way through review of the major issues discussed in the entire session.

Interpreting

Effective interpreting has three components — determining and restating basic messages; adding Counsellor's ideas for a new frame of reference; and checking out these ideas with the client.

It is very important that the Counsellor uses the skills of attending, paraphrasing, reflection of feelings and summarizing prior to and in conjunction with interpreting. The first step in interpreting is to determine the basic messages the client has expressed or displayed, and restate them. As the Counsellor is restating them, he will have some idea about alternative ways of viewing the client's situation, or may begin to see connections, relationships or patterns in the events the client describes. When these ideas are included in the material being restated to the client, the Counsellor adds his ideas to offer the client a new frame of reference from which to view his situation.

> *Counsellor — "You say you had difficulty in getting along with your parents. Once you mentioned that sometimes you simply broke the rules for the sake of breaking them. You have given up three jobs. Each time you said it was because of the highhanded behaviour of the boss. You feel you are unable to relate to the Warden here in the After-care Centre. Can it be a possibility, that you find it difficult to accept authority?"*

Because the Counsellor is offering alternative view points, it is very important to phrase them tentatively or to check out directly with the client his reaction to the new point of view. Tentative phrases like 'The way I see it.....' or 'I wonder if....' are appropriate ways to begin an interpretation. Then there is a greater possibility that the client will see the offered interpretation as a possibility rather than as a judgement. He is thus likely to react to an interpretation openly if it is offered tentatively.

Self-disclosure

Self-disclosure is the act of sharing and exposing the Counsellor's own feelings, attitudes and experiences with the client. The following guidelines should be kept in mind during self-disclosure.

- The disclosure should relate directly to the client's situation.
- The Counsellor should disclose only experiences that have actually happened to him (personal pronouns such as 'I', 'me', 'my' or 'myself' can give a clear message that it is one's own experience).

- The Counsellor should guard against any self-disclosure that is likely to shift the focus of the interaction away from the client to the Counsellor.
- The premature use of an intimate past experience or a threatening present feeling could make the client anxious and thereby damage the relationship.
- The Counsellor should guard against disclosing anything about himself that the client may ignore, deny or ridicule. If the client's perception of the Counsellor changes negatively because of an inappropriate self-disclosure, the relationship will be disrupted.

If self-disclosure is done properly, it will build a sense of trust and rapport between the Counsellor and the client. It helps to reduce the client's feelings that he is alone in the situation he is experiencing because he comes to realise that his Counsellor also had problems and made mistakes. It creates an atmosphere in which the client feels free to express content that he had previously avoided. It also enables the relationship to move to deeper levels by fostering a feeling of empathy.

Confronting*

Confrontation is the deliberate use of a question or statement by the Counsellor to induce the client to face what the Counsellor thinks the client is avoiding. The Counsellor may, for example, point out discrepancies between the client's verbal and non-verbal behaviours, between two of the client's statements, or between the client's past behaviour and his behaviour in the Counselling session.

In confrontation, the Counsellor identifies contradictions that are outside the client's frame of reference, whereas paraphrasing, reflection of feelings and summarizing involve responding within the client's frame of reference. In using confrontation, the Counsellor gives honest feedback about what he perceives is actually happening with the client. Confrontation should not include accusations, evaluations or solutions to problems.

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* This technique is dealt with in great detail in the chapter on 'Dealing with Denial' in our earlier publication **'Alcoholism and Drug Dependency — The Professional's Master Guide'**.

Sometimes the Counsellor may not know what to do after he attempts a confrontive response. The following guidelines may be of help.

- If the client accepts the confrontation and agrees with the discrepancy pointed out, the Counsellor can use the opportunity to reinforce positive behaviour.

  "I am happy that you are able to see the problem from this angle. Let us plan what we can do about it."

- If the client denies the confrontation, the Counsellor should return to an empathetic response.

  "You are finding it difficult to see the problem the way your family members and I perceive. It seems to be bothering you. Think about it. Let us talk about it later."

The client may not be ready at that point of time to deal with the discrepancy and it would not be helpful to persist in the confrontation. It can however, be dealt with at the appropriate point in time.

- The client may simply act confused or ambivalent after a confrontive statement. In that case, the Counsellor could focus on the current feeling.

  "You seem to feel confused by my statement. Let me make myself clearer."

An effective confrontation breaks down the defences of the client which he has consciously or unconsciously put up. It will enrich the condition of empathy in the Counselling relationship if the client perceives the confrontation as being done due to the care and concern of the Counsellor.

Silence

Silence can be very powerful. It can be a time when things really 'sink in', and feelings are really felt. When combined with 'attending' cues, it can serve to encourage the client to continue sharing. It can allow the client to experience the power of his own words.

The above mentioned qualities, skills and technical know-how in themselves are not sufficient to make a competent Counsellor.

The following attributes also contribute to the effectiveness of the Counsellor:

The Counsellor in after-care should

- Have all necessary information regarding chemical dependency including relapses and recovery.
- Be aware of his status as a role model for clients in the therapeutic community with regard to personal behaviour and attitude towards alcohol and other drugs.
- Be able to obtain complete and accurate information on client's problems and history.
- Be able to apply knowledge of addiction in counselling situations and help the client learn to apply this knowledge to his own problems.
- Be willing to show respect for the client and assist him in developing self-respect.
- Be able to assist the client in expressing feelings about his problems.
- Have the ability to assist the client in recognising and assuming responsibility for his behaviour.
- Be able to lead group counselling sessions; assist group members to express their feelings and draw insight from interactions within the group.
- Have the ability to handle crisis situations (client coming drunk, threat of suicide, medical emergencies) in a calm and effective manner.
- Be able to assist family members to develop productive behaviours and attitudes that will support the client's efforts towards recovery.
- Be able to identify the problem pertaining to the client's situation and develop a treatment plan to deal with that problem.
- Have the ability to recognise problem situations that are beyond the Counsellor's capacity to handle and refer such individuals to appropriate experts.
- Be able to maintain all records of the client upto date and complete.
- Take the trouble to keep in touch with former clients to follow-up on their progress and provide support.

Processes of counselling

★ Enhancing Motivation and Building Rapport

If the chemical dependent has come under pressure from somebody else (for example, his wife), the Counsellor's first task is to meet him alone. Even if the 'motivating party' is absent physically, she will be present psychologically; so his preoccupation should be removed before the counselling relationship with the chemical dependent can be established.

> *Counsellor — "I realise that your wife thinks you need extended help. But what I am mainly interested in at this point, is knowing how the situation looks from your point of view. What seems to be the trouble, as you see it?"*

Hopefully, as this approach is followed, the client will sense that the Counsellor is not taking sides with his wife in the struggle between them. He may begin to realise that the Counsellor is genuinely interested in understanding the situation including his perception of it and is prepared to help him. When this happens, the client will begin to lower his defences and risk some openness with the Counsellor.

It is important during the first interview to help the person verbalise his feelings. Whether the person comes under pressure or threat, or is merely fighting his inner resistances to admitting that he needs help, the Counsellor should assist him in getting his negative or conflicting feelings out into the open. Following are some of the factors which may make him avoid facing his need for help — his fear of the pain of withdrawal, of abstinence, his fear of not belonging to the 'peer group', his feeling that the drug is all that 'works' for him, the blow to his self-esteem of admitting loss of control, the fear of his socially unacceptable condition, etc. What is he worried, afraid, angry or frustrated about? What would he like to see changed? It is important that these inner barriers to admitting his need for help, be discussed with understanding and empathy by the Counsellor. If the person can bring his fear into the open, the help of the Counselling process becomes available for coping with them. As these feelings are being discussed, the Counsellor should let the person know, by his attitude, that he respects his right to whatever feelings he may have.

In working with any client, particularly the one who is resistant, it is important to discover his areas of hurt. It is at this point that the offer of help is most likely to be accepted. Often the 'hurt points' can be found by encouraging the chemical dependent to talk about his problems as he sees them.

The person's "Achilles' heel"— the place where he is motivable — is the place where he is hurt, worried, or is aware of some need for help.

> *"During those days, I didn't even bother to pay my daughter's school fees. So she had to discontinue her studies. Now I feel very upset..... very hurt!"*
>
> *"My boss had been so very understanding. I don't know how I used such language while talking to him."*

Such motivable areas have to be first identified, so that the Counsellor can work on those to enhance motivation.

★ Assessment and Problem Identification

Assessment is an on-going process in the therapeutic relationship, the first step in the formulation of a treatment plan. It is the process of data collection, clinical interpretation of that data, and development of a plan based on the strengths and weaknesses which emerge from the data. An assessment of a client includes his abilities, strengths, problems, needs and resources as well as his weaknesses, stresses or danger areas.

The purpose of this phase is to secure as much information as the Counsellor needs to understand the client as a whole. Therefore, one needs to view this process through four lenses — physical, psychological, social and the environmental context.

When carrying out an assessment, the Counsellor should first encourage the client to talk about what he wants. While being sensitive to his wishes, it is also necessary to look at the client's awareness of the damages caused and the extent of the problems. An inventory of these can then be compiled and the client may be asked to rank all the problems noted in terms of severity and urgency. When all the problems have been looked at in this way, the Counsellor should go on to consider them in the context of the person who is experiencing them.

What are the client's strengths and weaknesses?

What personal and social stresses are being experienced?

What is the goal preferred by him?

How is he going to achieve it?

In considering these aspects, the Counsellor will be considering the capacity of the person to achieve the various treatment goals which may be envisaged.

It is not possible to gather all the necessary information in one or two interviews. The Counsellor begins where the client perceives discomfort and proceeds from there. It is important for the client and the Counsellor to know at the end of each session where they stand in the process of assessment; what kinds of additional information will be necessary and what is expected before the next interview.

★ Goal-setting and problem Solving

Treatment goal spells out a desired result or destination for the client in the process of recovery and, in short, it is the reverse of the stated problem. For a client to agree that a goal is meaningful and worth working toward, it must be **clearly** related to his problem and **realistically** defined. The goal, therefore, describes what the Counsellor and the client would expect to see when a problem is resolved.

> *Problem: George does not have any formal training and feels low and frustrated that he couldn't get a job.*
>
> *("I can't get any job. So what is the point?")*
>
> *Goal: George will accept his need to get trained in a Vocational Guidance Centre.*
>
> – *He will visit the Guidance Centre.*
> – *He will identify the skill in which he wants to get trained.*
> – *Make plans with the authorities to undergo training.*

In treatment planning towards problem solving, the Counsellor should

– work with the client to formulate goals, objectives and acceptable alternatives for treatment that will increase the likelihood of a positive treatment outcome.

- consider a range of options in developing an individualised treatment plan, including the components of the continuum of care, the various treatment modalities, and formal and informal support groups.
- develop a complete, individualised treatment plan appropriate to the client's needs and resources as identified in the assessment process and acceptable to the client.
- assess progress towards treatment goals periodically with the client and modify treatment plans as indicated.

★ Resolution and Follow-up

Optimally, the completion of treatment should be jointly planned over a few weeks so that the client can get in touch with, adjust to and express his feelings related to discharge. It is very important to let the client know that although treatment is ending, progress has to continue. The need for regular medication, follow-up visits to the treatment centre, attendance at AA meetings should be emphasised. The client must continue the same self-exploratory attitude developed in the treatment.

The issues to be discussed should focus on enhancing and consolidating the gains achieved till then.

> *Counsellor — "In your three months' stay at the After-care Centre, you have got used to a structured and disciplined way of living. You are able to take others' criticism. You are taking up responsibilities and carrying them out. You have also learnt a new skill."*

Short-term goals and long-term goals should be clearly spelt out. Follow-up sessions should be planned so that the therapeutic relationship does not end abruptly. Regular follow-up for a period of one year should be emphasised. If the client has a relapse or if he doesn't turn up for a long period of time, it is essential that the Counsellor takes the initiative to contact the client.

Sometimes, 'drop out' or unplanned termination can occur. The Counsellor should learn to accept such terminations without feelings of guilt and anger over the "failure".

The new way of life of the recovering chemical dependent is a path along which he moves, and not a static goal which he achieves. *David Stewart describes 5 stages in sobriety

1. **Initial sobriety**: Physical health regained, preoccupation with sobriety, reduction of guilt and anxiety, increased self honesty.
2. **Learning sobriety**: Loss of freedom to become a social drinker accepted; give and take of real personal relations replace grandiose behaviour; regains acceptance of family and friends; sense of humour replaces self-pity; learning to cope with anxious or depressed states.
3. **Accepting sobriety**: Loss of desire to drink becomes lasting; thinking, feeling and ethical perception improves.
4. **Creative sobriety**: Freedom from alcohol deeply appreciated; religious desires centred on new way of life; appreciates need for help from others; uses new freedom in other activities.
5. **Pleasurable sobriety**: At peace with oneself and the world; anxiety and shyness diminish in genuine interpersonal relations; enjoys rewards of sobriety.

Sobriety is a new way of life, and it is a process. The role of the Counsellor is to help the client in this process so that he moves forward in stages towards a productive and meaningful future.

* This description of the 5 stages is abbreviated from Stewart's **"Thirst for Freedom"**.

Additional Information

Confidentiality

What exactly does the Counsellor mean when he promises confidentiality? 'Confidentiality' is safeguarding information about an individual that has been obtained by the Counsellor in the course of counselling. Sometimes, for the sole purpose of helping the patient, the Counsellor uses his discretion to disclose some information to significant people. When the Counsellor says he will maintain confidentiality, he assures the client that whatever he tells him, will be used responsibly and will be guarded against misuse.

There are two types of confidentiality — absolute and relative.

Absolute confidentiality

The security of information is absolute when data learned or observed by a Counsellor stay with him and are never passed on to any one else.

Relative confidentiality

Some of the information given by the client is shared with others in the system in a responsible manner as part of the treatment process.

In an inter-disciplinary setting, such as the After-care Centre, exchange of information will occur. Case histories will be discussed with other therapists in order to help clients.

For example, a case may be discussed with the Vocational Counsellor for rehabilitation.

As part of case discussion, information may be given to other Counsellors. This sharing is done with the intention of giving the client better help by seeking clarification from colleagues. A newly appointed Counsellor may find it necessary to consult a senior therapist regularly to discuss and get guidance regarding treatment strategies.

Some guidelines for maintaining confidentiality

Following are some of the most common instances in which violation of confidentiality is likely to take place. Inappropriate disclosures like these have to be guarded against.

★ **The Counsellor sharing details with his own family and friends**

This is one of the most frequent violations. The Counsellor may rationalise, "It's okay, as long as I don't use names. Besides, they don't know the people I am talking about. So what is wrong with discussing clients or work situations with my family members?"

The Counsellor who is tempted to share information, must first ask himself a basic question: "Is my friend or relative bound by the same rules of confidentiality as I am?" If the answer is 'no', then that person cannot be prevented from passing on the information to a third person.

It is acceptable for Counsellors to share **feelings** experienced as a result of daily activities, but here too names and specific details regarding clients and others should not be disclosed. Emotional reactions to confidential material rather than the confidential information itself can be shared. It certainly is permissible to state, "Oh! I had a frustrating day today — nothing went right", or

"A patient of mine had a relapse and it took everything I had to deal with it", or

"A client I have been working with for months, died today and I am really upset". Indeed, such release of feelings is essential, as friends and family provide the emotional support and empathy needed from time to time.

★ **Disclosure to the client's family members**

The Counsellor should be aware that certain information revealed by the patient need not be conveyed to his family members (e.g. pre marital/extra marital relationships). If the family is not staying with the client or is not involved in the treatment (for example, wife separated from client, not attending treatment programme), and they want to know some details about the client, the Counsellor should assertively say 'Sorry', and the information should not be given.

★ **Informal discussions with colleagues**

A Counsellor may be grappling with a client's problem when his colleagues join him during lunch or coffee break. There will be a tendency to ventilate feelings and discuss unresolved problems during that break. Sometimes, these indiscreet conversations can be overheard

and may lead to problems. Therefore, information should be shared only in privacy and in a professional manner with the purpose of helping the client.

★ **Inappropriate remarks to co-workers and other patients**

Every patient should be treated with dignity and any inappropriate remark about him to other patients or co-workers should be avoided.

For example

"Hello Mr. Prakash — I am sorry I had to keep you waiting for so long — the other client just went on and on".

Another example is,

Counsellor — 1 *"Hello VSG., what is wrong with Mrs. Ravi? Has she fought with her husband again?"*

Counsellor — 2 *"Yes. She has started again..... Had a big fight with her husband."*

Such discussions should be avoided.

★ **Recognising the client outside**

The Counsellor may see the client at social functions, in cinema halls, hotels etc. Unless the client acknowledges and talks to the Counsellor, the Counsellor should not take the initiative and recognise the client.

★ **Release of information to others**

Someone other than the client may seek access to information contained in the records. The principle is that the client's consent should be obtained before any confidential information about him is disclosed. First the client must be told that there is a request for certain data. He must be made aware of the following details:

- who has asked for the information
- what information they have asked for
- the purpose of their request

He should also be fully informed of any repercussions that might occur.

Common sources of request for information

A few sources that may ask for or need confidential information from records are listed below.

★ **Family and friends of the client**: It is natural to assume that family and friends always have the client's best interests in mind and should therefore be given whatever information they want. This is not always true. Therefore, the client has to be consulted before any information is passed on. A standard response may be "I'm sorry; I am unable to give you that information. I'll contact the client, and if he gives permission, I will get in touch with you. Or, I will ask him to contact you directly."

The caller may insist that he has already obtained the client's permission. Still this statement should not be taken for granted. A formal written consent from the client should be obtained. Usually, families of chemical dependents would ask for certificates of treatment taken at the centre for the purpose of divorce, claiming of child, property, job etc. These certificates **should not** be issued without the client's consent.

★ **Legal authorities**: No information should be passed on to legal authorities (court, police etc.) unless they come with a formal request, or send the orders through the proper channel. Even then, the information should be addressed to the source of request/appropriate authority only.

★ **Employer**: If the client has been referred by the employer, limited, relevant information can be passed on to the employer. If the employer has not referred, then no information need be given.

★ **Non-clinical staff**: They should not gain access to patients' records.

★ **News media**: No information pertaining to clients should be given to the news media and no photographs taken without prior permission.

★ **Others**: Information with regard to treatment facilities, charges, duration, availability of beds etc., can be given to the public. On the other hand, the Centre may get telephone calls asking if a particular person has been admitted, taken treatment earlier etc., for which

no information should be given, as the caller could contact the respective family for such information.

Thus, maintaining confidentiality is an integral part of the treatment process, since it lays the foundation for mutual trust and confidence, which is very vital to a positive client-counsellor relationship.

Counsellors' Burnout

Professionals working in the field of addiction treatment are prone to stress. When this stress is not managed properly, it becomes an overload and leads to 'burnout', making the job tedious, draining and frustrating. It results in the Counsellor feeling exhausted and worn out. He feels physically and emotionally drained. From a position of helpfulness, care and concern for his patients, his condition turns to one of frustration and apathy.

Why does burnout happen?

Repeated unresolved problems in work situations lead to stress. Totally uncooperative, highly demanding and manipulative clients, patients repeatedly violating rules and frequency of relapse; are some of the contributing factors for a Counsellor's burnout. Family problems, stress at home, lowered stamina of the Counsellor due to physical illness, also have a bearing on his ability to cope. Interpersonal conflicts and problems in relationships among members of staff activate stress. Lack of clarity of roles, leading to overload of work on one Counsellor and a non-supportive working environment can result in a Counsellor's burnout.

The resultant burnout manifests itself physically as fatigue, headache, insomnia and backache. The body literally breaks down and is no longer able to manage. The mind also switches off.

The Counsellor experiences depression, anxiety, feelings of frustration and anger. The syndrome also includes apathy, weariness, lack of personal involvement and a lack of enthusiasm for the patient's rehabilitation.

Burnout is an inevitable consequence of ineffective identification and management of stress. Since burnout is not an uncommon condition in treating chemical dependents, Counsellors should be forewarned and prepared to take a variety of coping actions, all of which will lessen stress on themselves, their work, their relationship with clients and their communication with their fellow workers. By identifying stress contributors and developing strategies to deal with them, a Counsellor may be able to avoid 'burnout' before it becomes a problem. If this

problem is not handled properly, it will not only make the individual ineffective, but also bring down the staff morale.

Dealing with burnout

★ Good interpersonal relationship among staff is a must for any treatment centre. Honest and open communication among staff, leads to a healthy, supportive environment which will lower the incidence of stress.

★ Senior Counsellors can teach newcomers on what to expect from troublesome clients and how to handle their own emotions.

★ If one Counsellor is not able to stand the stress and tackle a particular patient, sharing of the burden with other Counsellors will definitely lighten his strain. When he is pent-up at times, it is therapeutically good to share the problem with someone and arrive at a reasonable solution together.

★ When a Counsellor is under stress, he can reduce the number of hours given for counselling for the time being. He can relax by taking up other activities like writing letters to treated patients, filling up case files and reading professional journals.

★ The Counsellor should understand that relapse is an integral part of the recovery process. He need not feel guilty or frustrated if a patient relapses in spite of his honest efforts. The professional can, at best, only help the patient to deal with his relapse, if it does occur. However, if repeated relapses happen, the Counsellor can discuss the cases with senior Counsellors and ensure that his plan of action and anticipatory guidance are proceeding in the right direction.

★ Apart from the daily therapeutic programme, they can periodically organise self development programmes which will enhance their creativity and also help them in strengthening their self-esteem.

★ Recovered persons may be encouraged to celebrate their birthdays (drug-free abstinent years) at the After-care Centre. This will bring about a sense of gratification to the Counsellor, while at the same time, it will provide incentive and hope to the recovering patients.

★ Some provision can be made in the After-care Centre for the Counsellors to have a break from the routine — an occasional outing or a picnic with other staff members.

★ Small things like not taking one's work home, getting sufficient rest, talking about problems at work while at work, developing variety in one's work and reducing the repetitive routine aspects of it wherever possible, will definitely help in reducing or preventing "Counsellors' burnout."

Individual treatment plan*

Counsellors have increasingly felt the need to provide help specifically tailored to the individual need of each client. Since chemical dependency is a complex, multifaceted problem, it becomes essential to develop treatment plans specific to each client who comes to After-care Centre for treatment.

The treatment plan gives both the Counsellor and the client a structure in which they can function. Expectations become clear, and misunderstandings are relatively easy to resolve. Treatment plan allows Counsellors to clearly specify goals, monitor and evaluate progress. With such a plan, counselling can proceed in a straightforward, outcome-oriented fashion. Without it, the client-counsellor relationship will be poorly defined, unstable and unlikely to succeed.

The treatment plan can be simple or elaborate, provided it addresses all the problems to be dealt with in treatment. The client's chemical dependency must be viewed in the context of other life problems, although not necessarily in terms of causality. Chemical dependency tends to be associated with a variety of social, psychological, family and financial problems.

Each of the client's major concerns should be addressed as part of the counselling process under the assumption that a favourable outcome involves rehabilitation across several life domains.

An individualised treatment plan is developed for each patient on or about the seventh to tenth day of treatment. This is then made a part of the patient's record. Weekly notes are made in the patient's record indicating progress in implementing the methods outlined in the treatment plan as also any revisions or alterations. At least one treatment plan update is made within the next two weeks to formally reflect progress or lack of progress or alterations to the treatment plan.

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* We acknowledge the valuable contribution of Mr. S. Mohan of Delhi, who has completed a course in Counselling skills in USA, towards writing this chapter.

The treatment plan must include

- ★ The patient's acceptance of his addiction, and the need to have total abstinence as his recovery goal.
- ★ The Counsellor's identification of the motivable areas and plans to enhance motivation.
- ★ An assessment of all problem areas — physical, psychological, social, occupational and environmental.
- ★ Identification of character defects which may interfere in the recovery process.
- ★ Identification of vocational skills to be learnt and developed.
- ★ The patient's support system to be strengthened.
- ★ The patient's relapse triggers to be identified, and coping methods to deal with them, to be developed.
- ★ Identification of some positive ways of having fun.

In order to achieve treatment goals, specific methods should be stated. These should be realistic and practical. After implementation, they should be evaluated and then documented in the patient's progress notes, case consultation notes and group notes. Each goal in the treatment plan should have a specific time frame for completion.

Certain other issues are also to be kept in mind before making a treatment plan.

- ★ Assessment of the extent and intensity of denial in the client is important. A client with severe denial may require more therapy hours to handle this, before other issues are raised.
- ★ The extent and seriousness of a particular problem in a patient may sometimes call for priority. The patient may have one problem as a top priority item to be dealt with, whereas the Counsellor may feel that some other problem needs immediate attention. In such cases the Counsellor and patient must jointly articulate their respective preferences and then, through mutual agreement, determine treatment goals.
- ★ The involvement of significant others is quite important. As the entire family has become dysfunctional, the family or other people close to the patient should invariably be included. Counsellors should set the stage to strengthen family relationships, so that the patient gets their support during recovery.

Treatment plan update

A treatment plan update must be completed for each patient and entered into the patient's record every two weeks. This can be done after two weeks of therapy or when there is a major shift or change in the treatment direction or patient status.

The treatment plan update can be written in a progress note form, and must relate specifically to the treatment plan objectives, goals achieved and dates of completion. If the target date has not been achieved, there should be a statement as to why this is so, and new target dates should be specified. The Counsellor may need to abandon one particular goal from the treatment plan, when it is no longer applicable in the light of new information. In such cases, the therapist should mention this in the treatment plan update.

Treatment Plan

Name: Mr. S

Goal	Methods to achieve the goal	Target Date for completion	Actual Date of completion
1. To understand the need to stay at the After-care Centre.	1. Talk to 4 patients who have been in the programme for more than two months and understand the benefits derived by them.	25-08-92	27-08-92
	2. Write down what you expect to gain from this programme.	28-08-92	28-08-92
2. To realise in-depth, the various damages caused by addiction.	1. To prepare notes on your 'life history'.	03-09-92	04-09-92
	2. Share this in the group and get their feedback as to whether the sharing was 'honest and in-depth'.		

Goal	Methods to achieve the goal	Target Date for completion	Actual Date of completion
3. To get totally involved with the programme of the Centre.	1. Meticulously attend the programme schedules — classes, group therapy, A.A., etc. 2. Get involved in morning exercise sessions/recreational activities in the evening.	06-09-92 to 25-09-92	25-09-92
4. To deal with anger appropriately.	1. Attend re-educative class on 'Anger Management'. 2. Write assignment on that topic. 3. Discuss this with the Counsellor. 4. Play 'Feelings Game' ('Ungame') with the other group members. 5. Practise relaxation techniques.	17-09-92	29-09-92 (Patient fell sick; hence could not complete it on time)
5. To improve relationship with parents. To establish stable recovery	1. Parents to attend 'family sessions' and meet the Counsellor. 2. Help mother in cleaning the house prior to Deepavali festival. 3. After every weekend 'outing', give feedback to the Counsellor of efforts taken to improve the relationship with parents.	On-going	

Goal	Methods to achieve the goal	Target Date for completion	Actual Date of completion
6. To improve self image.	1. Share five of your positive qualities with the group. 2. Talk about five qualities you want to have or develop. 3. Identify one quality among them and communicate to the group as to how you are going to develop it.	01-10-92	02-10-92
7. To get over the qualities of procrastination and selfishness.	1. Make efforts to help new comers at the centre. 2. Take up specific tasks at home during week ends – Buying vegetables/provisions for the family. – Watering plants. 3. Complete therapeutic duties of each day at the alloted time; give permission for Mr. LN to point out whenever you have not completed on time.	12-10-92	14-10-92
8. To develop a skill.	1. Learn 'Tamil Typewriting' and prepare for 'Lower' Exam. 2. Spend half an hour every day on practice. 3. Periodically communicate your progress to the Counsellor.	30-11-92	30-11-92

Goal	Methods to achieve the goal	Target Date for completion	Actual Date of completion
9. To enjoy recreational activities.	1. Play carrom with other patients twice a week. 2. Try and find out which games you are interested in and spend one day every week in playing that game.	On-going	
10. To develop a recovery support system.	1. Identify a sponsor in A.A. 2. Ask him to meet your Counsellor. 3. Give him full permission to assess and communicate your strengths and weaknesses.	10-11-92	12-11-92

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21
VOCATIONAL REHABILITATION

Research studies repeatedly demonstrate a strong link between 'staying clean' and having a job. This vital relationship is usually well known to treatment professionals and is also acknowledged by recovering people. Most notably, employment means legitimate income and a constructive activity, which help in increasing self-esteem and developing healthy coping skills. Employment helps in the overall growth of the patient.

Addiction would have led to damages in the area of employment. The chemical dependent might not have completed his academic career, and therefore, may not be able to get back to any vocation. Many of them, even if they are employed, may not have a consistent track record. They might have been shifting from one occupation to another. They would not have bothered to update their knowledge or skills. Therefore, during recovery, there is a specific need for their vocational rehabilitation.

In dealing with this issue, what is crucial is the initial assessment. The Counsellor should at the start, distinguish between two types of problems clients may face

- difficulty in reintegration into place of work.
- currently unemployed, and hence requiring guidance to look for a suitable job.

If the chemical dependent is employed, he may be facing the consequences of previous disciplinary problems like absenteeism, interpersonal conflicts etc. at work spot. This may cause stress to the client.

The first step in handling this would be to collect a detailed history with regard to the following.

- how many years of service he has put in
- what are the problems caused by addiction in his job
- what are the disciplinary actions he has to face. Any urgent issue which needs to be looked into immediately (eg. under suspension)
- what is the nature of work. Assess if the nature of work is conducive to sobriety. (eg. Does it give him an opportunity to attend A.A. meetings, to come for regular follow-up.)

After collecting the data, the Counsellor should look for the blocks within the client which may be making him uncomfortable to go back to work. More often, these blocks will be at the feeling level. Clients may feel ashamed to face their colleagues, may be anxious to relate to their authorities, may be afraid of disciplinary action, may be apprehensive of curious questions, teasing etc. The Counsellor should help him share his feelings in depth with the group. If necessary, the Counsellor could discuss relevant issues like the nature of treatment given, the need for follow-up etc. with the personnel department. However, this has to be done only with the consent and participation of the client. After the client resumes duty, he should be encouraged to share his feelings with the Counsellor and the group. An on-going, parallel emotional support will positively assure his smooth re-entry into the workspot.

There may be some clients who would be unemployed at the time of admission. These clients may need help in looking for a suitable vocation.

In such cases, assessment should include the following.

- any job held so far. Details about jobs held, nature of work, reasons for quitting etc.
- current skills and abilities.

Depending on the assessment, the Counsellor should help the client to identify job opportunities. A few guidelines, to be kept in mind while discussing this issue are given below.

- If client has a track record with short stints at various jobs, an in-depth analysis into the difficulty in retaining a job would be useful. (It may not be chemical dependency alone. For example, it may be difficulty with interpersonal relationships).

- If any updating of skills by attending a short refresher course could increase the employability of the client, he should be encouraged to do so. When referrals are made, the focus should always be on the patient's need and the market need. It is improper to refer the patient to a particular agency simply because it has connections with the After-care Centre.
- Some jobs may not be safe for recovering people. It is wise to consider carefully any employment opportunity in terms of how it may help or hinder recovery and, if one accepts it, be prepared to manage problems. For example, jobs involving travelling, especially, sales job, starting a new business venture etc.
- During the initial stages of recovery, the environment can also be stressful, especially because the person is adjusting to a drug-free life style. For example, long hours of work, night shifts, etc. Client should learn to combat this stress through healthy ways.

Thus employment would help the client have

- a structure and purpose for his time and energy.
- a positive social environment.
- a sense of accomplishment.
- a continued experience of personal growth and development.

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SOME MORE IMPLEMENTATION TOOLS

'Staying sober' implies that the client starts thinking clearly and plans his life appropriately in order to sustain his drug-free life. Assignments have been found extremely useful to help recovering patients understand their thoughts and feelings and realise how much these have a bearing on their lives. In this chapter, various assignments that can be given to patients, have been discussed. Each assignment can be given to patients after they have attended the re-educative lecture on that particular topic. Submission and discussion of assignments are found very useful in the process of helping patients towards sobriety.

Assignment – 1

Damages in the area of education

As chemical use progresses, school and college often become less important to the chemical dependent. What was once of high priority, now gets pushed down the list to make way for drugs and a drug-centred life style. To understand this, please complete the following chart.

i) Demarcate three or more stages of drug use and abuse in chronological order, starting with the recent past.

Percentage of Marks Obtained In School/College	**Rank Received In Classes**	**Degree of Involvement In Drug Use**

Assignment – 2

How chemicals affect the ability to have fun

People usually begin using drugs in a social situation as an addition to whatever activities they are involved in. Activities include hobbies, sports, viewing movies etc. During this stage, fun and pleasure are centred on **people**/that particular **activity**, and **not** on the chemical. As drug abuse progresses, the centre of fun slowly shifts from the activity to the drug. Eventually, very little pleasure is derived from an activity unless the person is 'high'.

In your case,

i) What kind of activities did you enjoy before using drugs? How often did you participate in those activities?

ii) Of late, how often have you enjoyed each of those activities? During those moments, were you sober or 'high'?

iii) Has using chemicals affected your ability to have fun? If so, how? Give specific examples.

Assignment – 3

How chemicals weaken self-esteem

Self-esteem is essentially a measure of self-worth and importance. When a person has positive qualities, his assessment of himself will be level headed and reasonable. He will develop a strong self-esteem and will be contented. When a person has too many negative qualities, his assessment of himself will be low and poor. He will feel inadequate and will develop a weak self-esteem.

Drug abuse affects every area of a person's life. In this process, it weakens a person's self-esteem.

Given below is a list of some qualities a person may possess.

- Good in sports
- Spiritual
- Friendly
- Self centred
- Intelligent
- Dishonest
- Lazy
- Sensitive

- Impatient
- Artistic
- Courageous
- Unfriendly
- Open minded
- Hopeless
- Rebellious
- Stubborn
- Helpful
- Clumsy
- Honest
- Cowardly
- Kind
- Creative
- Energetic
- Takes things for granted
- Gets along well with people

i) Write down five positive qualities you had, before you started using drugs.

ii) How did significant people refer to you while you were using drugs (Irresponsible, selfish, lazy etc.)?

iii) Write down five positive qualities you would like to get back now.

Assignment – 4

How chemicals affect feelings

Some examples of feelings — happy, sad, angry etc. Drugs have the ability to block or alter one's feelings. Drug dependent people rely on chemicals to take care of their feelings — "If you feel sad, get 'high' and feel good. If you feel lonely, get 'high' and feel better." The problem with this is when the person is not 'high', these negative feelings will come back. After a while, it will almost be impossible to get through these feelings without resorting to drugs. It is very important to be able to deal with feelings without resorting to drugs. It is for this reason that the ways in which you had handled feelings in the past must be examined.

The following example will help you understand the process.

> *Ram's son got the first rank in his class. He had shared his happiness with his grand parents and even with neighbours. He did not inform Ram. When Ram came to know about this from his in-laws, he was deeply hurt. "Look! he has not bothered to tell me!" Instead of discussing the issue with his son, he went out and got drunk to escape from his hurt.*

i) Specify how you had dealt with the following feelings while you were on drugs — clearly describe the situation, your thought and behaviour.
   - Resentment
   - Over sensitivity to criticism
   - Fear/Anxiety
   - Inferiority
   - Self Pity
   - Rejection
   - Happiness
   - Boredom

ii) In what ways have you blamed others or circumstances for your problems? Be specific with examples.

Assignment – 5

How chemicals interfere with friendship

As a person starts abusing drugs, his circle of friends changes. He is no more interested in friends who do not use drugs. He makes new 'friends' who are in tune with his drug-taking behaviour. During recovery, one realises that his 'so called friends' are not real friends but only 'drug-using companions.'

i) What are the qualities you notice in your 'drug-taking friends'?

ii) What kind of qualities do you now look for in your friends?

iii) What are the activities you are planning to carry out with your new friends?

Assignment – 6

Giving reasons for chemical use

As drug abuse progresses, drug users depend on drugs to escape from problems, and keep on justifying their use. (For example, they rationalise that they use drugs during tense moments like arguments, during a particular activity, in a social situation etc.) During recovery, these situations may occur again. Therefore, it would be helpful if you remember how you had handled them before, so that you can plan methods to handle them from now on.

Given below is a list of situations you may face now. State the plans you have made to handle these 'high-risk' situations.

- You happen to meet others who are using drugs
- When you are alone
- During arguments at home
- At school/college when there is a 'cultural'
- When someone suspects you
- If your family members ignore what you say
- While involved in an activity which you had been doing formerly while you were abusing chemicals
- When in social situations

Assignment – 7

How chemicals destroy values

A man is normally known and acknowledged only by his values. Sometimes, using chemicals becomes more important than certain values. One may have to go against these values to use drugs. When this happens, he experiences guilt. Using drugs may mask these feelings of guilt, but they are still there. Feeling guilty often causes people to want to get 'high' again. To get these drugs, he may again have to go against his values causing more guilt and more pain. This is a self defeating pattern.

Given below are some values. While this is not a complete list, it will give you a good idea of what values are. Read the list slowly and carefully and then answer the questions.

Honesty
Loving
Responsibility
Discipline
Punctuality
Following family traditions
Spending money wisely
Helpful
Trust in God
Listening
Open mindedness
Hard work
Respect for elders
Giving importance to education
Good health
Alcohol/drug-free life
Gratitude
Cleanliness
Patience
Orderliness

i) List five values you had, before you started using drugs.

ii) Did you 'break' any value during your 'drug-taking days'? Be specific about the situation and your behaviour.

iii) What are the values you would like to get back now?

Printed by TT. Maps & Publications Limited,
328 G.S.T. Road, Chromepet, Madras-600 044.

Published by Mrs. Shanthi Ranganathan,
T T Ranganathan Clinical Research Foundation,
17, IV Main Road, Indira Nagar, Madras-600 020.

Distributed by Mr. J. Srinivasan
T T R Education Foundation,
17, IV Main Road, Indira Nagar, Madras-600 020.

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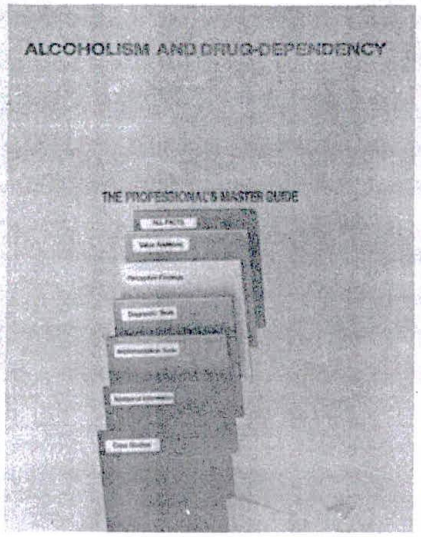

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