ALHOLISM AND DRUG DEPENDENCE

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CHENNAI.

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PART — A

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1
DRUGS — A CLOSER LOOK

When a pharmaceutical preparation or naturally occurring substance is used primarily to bring about a change in some existing process or state (physiological, psychological or biochemical) it can be called a 'drug'. In simpler terms, any chemical that alters the physical or mental functioning of an individual is a drug.

Drugs may or may not have medical uses; their usage may or may not be legal. When drugs are used to cure an illness, prevent a disease or improve the health condition, it is termed 'drug use'.

When drugs are taken for reasons other than medical, in an amount, strength, frequency or manner that damages the physical or mental functioning of an individual, it becomes 'drug abuse'. Any type of drug can be abused. Drugs with medical uses can also be abused.

With medically prescribed drugs, drug use and drug abuse can be differentiated. Drugs with medical uses can be abused in the following ways:

Too much: Taking an increased dosage without medical advice. e.g. Taking 10 mg of valium when only 2 mg has been prescribed.

Too often: Taking small doses frequently. e.g. Taking the drug during day-time when a bed-time dosage alone has been prescribed.

Too long: Taking the drug for an extended period of time — longer than the prescribed period. e.g. Continued use of the drug for months when the physician has advised usage only for a fortnight.

Wrong use: Taking a drug for reasons other than medical, for which it is intended, or taking a drug without medical advice. e.g. Taking Gardinal (an anti-epileptic drug) for the sedative side-effects it produces.

Wrong combination: Taking a drug in combination with certain other drugs. e.g. Taking barbiturates (a depressant drug) with alcohol to enhance the effect.

Illegal drugs like brown sugar and ganja have no medical use at all. With these drugs, there is no 'drug use'. To use them is to abuse them. From the very outset, it is drug abuse.

Drug abuse leads to drug addiction with the development of tolerance and dependence. **Tolerance** refers to a condition where the user needs more and more of the drug to experience the same effect. Smaller quantities, which were sufficient earlier, are no longer effective and the user is forced to increase the amount of drug intake.

Some drugs produce only psychological dependence while others produce both physical and psychological dependence.

Psychological dependence is a state characterised by emotional and mental preoccupation with the effects of the drug and by a persistent craving for it. When psychological dependence develops, the user gets mentally 'hooked on' to the drug.

When **physical dependence** develops, the user's body becomes totally dependent on the drug. With prolonged use, the body becomes so used to functioning under the influence of the drug, that it is able to function normally only if the drug is present.

After the user becomes dependent, if the intake of drugs is abruptly stopped, **withdrawal symptoms** occur. In a sense, the body becomes 'confused' and 'protests' against the absence of the drug. The withdrawal symptoms may range from mild discomfort to convulsions, depending on the type of drug abused. The intensity of withdrawal symptoms depends on the type of drug abused, the amount of drug intake and the duration of abuse.

These withdrawal symptoms make it difficult to give up drugs. The user is seemingly caught in a web of his own making. He wants to avoid the unpleasant withdrawal symptoms; to avoid them he needs the drugs. The addict is thus forced to continue drug use even when he knows that drugs are hurting him.

Classification of addictive drugs

Addictive drugs are classified in various ways based on their origin, chemical structure, mechanism of action etc. When classified according to their effects on the user, addictive drugs can be classified into **FIVE** major categories:

1. Narcotic analgesics
2. Stimulants – Nico / caff / Ampli / Cocaine
3. Depressants – Barbit / Benzodi
4. Hallucinogens – LSD, PCP, Mescaline
5. Cannabis*

The first four categories are dealt with individually in the following pages. Detailed information about cannabis can be found in the chapter on 'Cannabis'.

* For a long time Cannabis was classified as a hallucinogen. But since a few effects like flashbacks do not occur with cannabis a separate category was created.

Narcotic analgesics

In Greek the prefix 'narco' means to 'deaden' or 'benumb'. Analgesic means pain-killing or pain-relieving. The term 'narcotic' medically refers to opium and opium derivatives or synthetic substitutes that produce opium-like effects.

All narcotic analgesics share the common property of benumbing and thus relieving pain. As a class, they are painkillers with a high addictive potential.

Drugs belonging to this category can be studied under three broad categories — narcotics of natural origin, semi-synthetic narcotics and synthetic narcotics. Drugs belonging to the first two categories are referred to as **opiates** while the synthetic drugs are known as **opioids**.

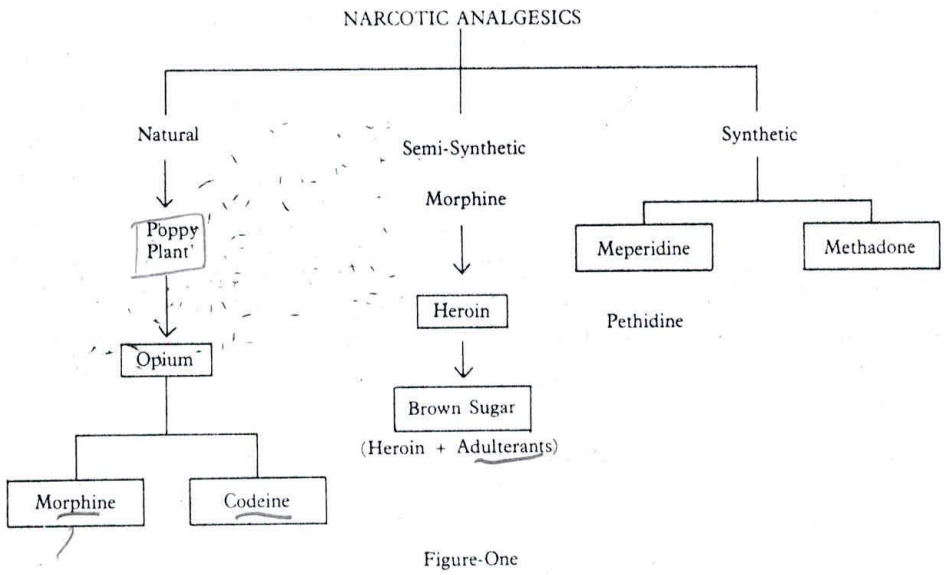

Figure-One

Narcotics of natural origin

The poppy plant, 'Papaver Somniferum', is the source of naturally occurring narcotic drugs. For thousands of years this plant has been widely cultivated for its pleasurable effects. Today, its cultivation has been restricted by law.

Opium

Opium is made from the milky fluid that is collected from the unripe pod of the poppy plant. Opium is a dark greyish or brownish tar like substance.

Opium is smoked, chewed and absorbed through the mucuous membranes of the mouth. It is also boiled with water and drunk.

Detailed information can be found in the chapter on 'Opium'.

Morphine

Morphine is the principal alkaloid that is extracted from opium. (An alkaloid is a type of drug which can be extracted from a plant.) About 10 — 15% of the opium exudate contains morphine. Morphine is one of the most effective drugs for relief of pain. It is still used medically.

Routes of administration

Injected — subcutaneously, intramuscularly or intravenously. Most morphine addicts use the intravenous route.

Codeine

Codeine is another alkaloid found in opium though in a smaller percentage than in morphine (one to two percent).

Codeine is used in cough-suppressant drugs and anti-diarrhoeal preparations.

Routes of administration

Injected — subcutaneously or intramuscularly.

Oral — medical preparations of codeine are usually made in combination with other chemicals and are available in the form of tablets and syrups.

Codeine is very rarely abused as its analgesic effects are mild and severe side effects (e.g. convulsions) are often experienced.

Semi-synthetic narcotics

Heroin/Brown sugar

Heroin (di-acetyl morphine) is a semi-synthetic derivative of the drug morphine. Brown sugar is the adulterated form of heroin. Brown sugar is smoked or 'chased'.

Detailed information can be found in the chapter on 'Heroin'.

Synthetic narcotics

Synthetic narcotics are produced only in the laboratory. These drugs imitate the effect of the opiates but are not prepared from opium. Pethidine and methadone are the most widely available synthetic narcotic drugs.

Meperidine

Meperidine [Pethidine(R)] is probably the most widely used drug for the relief of moderate to severe pain.

Routes of administration

Oral — Meperidine can be administered orally in the form of tablets.

Injected — subcutaneously, intramuscularly or intravenously.

Pethidine addicts almost always inject the drug intravenously.

Methadone

From the 1960's Methadone received wide recognition in the area of narcotic addiction treatment in the United States. It later became a part of heroin addiction treatment. Ironically, later on, many got addicted to methadone and it became the major cause of overdose deaths. Since then, it's use has declined.

Routes of administration

Methadone is almost as effective when administered orally as it is by injection. So methadone is usually taken in the form of tablets.

Short-term effects of narcotic analgesics

When injected, the effects are immediate and pronounced. With other routes of administration, the effects are felt only gradually.

The main effects include:

— a short-lived state of euphoria during which feelings of hunger and pain are not felt.
— mental clouding — impairment of intellectual processes
— drowsiness, apathy, decreased physical activity
— reduced heart rate and blood pressure
— constipation
— constriction of pupils (with the exception of synthetic narcotics)

A few adverse reaction may also appear:

— nausea, vomiting
— dysphoria (a feeling of unpleasantness)
— increased sensitivity to pain after the initial effect wears off
— itchy skin

With large doses, pupils constrict to pin point size and respiratory depression becomes more pronounced. With an overdose, cyanosis develops in which skin becomes cold, moist and bluish. Convulsions occur which may be followed by respiratory arrest and death.

Long-term effects

Severe constipation, contracted pupils and moodiness are some of the long-term effects. Chronic users may develop lung problems due to its effects on the respiratory system. Infection can be caused by unsterile needles. Abscesses (pus formation), cellulitis (inflammation of connective tissues), liver damage, tetanus and brain damage are the other problems which may develop.

Tolerance and dependence

Tolerance develops fairly rapidly making higher doses necessary to maintain the intensity of its effects. The narcotic analgesic class of drugs is highly addictive, and regular use results in severe physical and psychological dependence.

Withdrawal symptoms

The withdrawal symptoms of narcotic analgesics are more painful and severe, compared to the withdrawal symptoms of other categories of drugs. The severity of withdrawal symptoms will depend on the type of narcotic used, the amount, the duration of use and the general health condition of the person.

With the deprivation of narcotics, the first withdrawal symptoms are usually experienced shortly before the time of the next scheduled dose. Although withdrawal can cause considerable suffering, the initial symptoms resemble those of a moderately severe bout of influenza. Throughout, complaints, pleas and demands of the addict are prominent. Symptoms such as watery discharge from eyes and nose, yawning and perspiration appear about 8 to 12 hours after the last dose. Restlessness, irritability, loss of appetite, goose flesh, tremors, pupilary dilation, yawning and severe sneezing also occur. Thereafter the addict may fall into a restless sleep. Withdrawal symptoms intensify and reach their peak between 48 and 72 hours after the last dose. The patient becomes weak and depressed. Nausea and vomiting occur. Stomach cramps and diarrhoea are common. Heart rate and blood pressure are elevated. Chills alternating with flushing and excessive sweating are also characteristic symptoms. Excruciating pain in the bones and muscles of the back and extremities occur as do muscle spasms and kicking movements. At this time the individual may develop suicidal tendencies.

Without treatment, the syndrome eventually runs its course and most of the symptoms will disappear within 7 to 10 days. The time taken to restore physiological and psychological equilibrium, however, is unpredictable. For a few weeks following withdrawal, the addict will continue to think and talk about his use of drugs and be particularly susceptible to an urge to use them again.

Stimulants

Stimulants are drugs which excite or speed up the central nervous system. The two most prevalent stimulants are nicotine, found in tobacco products, and caffeine, the active ingredient in coffee and tea. These however will not be discussed here. The more potent stimulant drugs will be the focus of attention. They include amphetamines and cocaine.

Amphetamines

Amphetamines are synthetic drugs produced entirely within the laboratory. Amphetamine, dextroamphetamine and meth-amphetamine collectively come under

the term amphetamines. The effects produced by these three are the same and can be differentiated only by clinical analysis.

Amphetamines are still used medically to treat narcoplexy (an uncontrollable tendency to sleep) and hyperkinetic behaviour in children (excessive activity and short attention span).

Amphetamines are sometimes used in weight control programmes, in the treatment of mild depression and to provide relief from fatigue. Amphetamines however are now recognised as a poor choice for treating these disorders.

Amphetamines are white, odourless, crystalline powders with a bitter taste. Illicit varieties include fine or coarse powders and crystals that are off-white to yellow in colour. They are supplied loose or in the form of capsules and tablets.

Amphetamines are usually abused by:

- students, to ward off sleep, enabling them to study through the night prior to the examination
- athletes, to mask feelings of fatigue and increase their endurance.
- Busy executives often abuse both stimulants ('uppers') and depressants ('downers') — the stimulant to increase their activity during the day and the depressant to calm down the sleep during the night.

Routes of administration

Oral: Amphetamines are absorbed orally and are taken in the form of tablets or capsules.

Cocaine

Cocaine, a potent stimulant of natural origin, is extracted from the leaves of the coca plant (Erythroxylon coca).

Cocaine was formerly used in eye, nose and throat surgery because of its ability to anaesthetize tissues and simultaneously constrict blood vessels and limit bleeding. It is no longer employed medically.

It is an odourless, white, crystalline powder, with a bitter numbing taste. Street cocaine is often adulterated with other chemicals.

Routes of administration

Oral: The leaves of the coca plant are sometimes chewed and cocaine, the chief psychomotor chemical present, is absorbed through the mucuous membranes of the mouth.

Snorted: Cocaine is usually 'snorted' or taken in through the nasal passages (like snuff).

Very rarely, cocaine is injected for a heightened effect.

Short-term effects of stimulants

Amphetamines and cocaine have different mechanisms of action but the overall impact is the same and their effects parallel each other very closely.

The main effects include:

— a heightened feeling of well being, euphoria (elation)
— a sense of super-abundant energy, increased self-confidence
— an increased motor and speech activity
— a suppression of appetite (which is why it is used in diet pills)
— an increased wakefulness that masks feelings of fatigue (the reason why amphetamines are abused by students during examinations).

Pupilary dilation, dryness of mouth, increased respiration, heart rate and blood pressure, reduced gastrointestinal activity and urinary retention are other effects.

Unpleasant effects such as temporary impotence, anxiety or even panic may be noticed.

With large doses, very rapid heart beat, hypertension, headache, profuse sweating, severe agitation and tremors may occur. Very high doses cause rapid, irregular and shallow respiration, convulsions and coma.

Long-term effects

Chronic sleep problems, poor appetite, high blood pressure, rapid and irregular heart beat, impotence, mood swings, anxiety and tension states are the long-term effects of stimulant abuse.

Acts of violence, homicide and suicide rates among stimulant abusers are high.

Chronic use may produce 'amphetamine psychosis'. Paranoid ideations, hallucinations and purposeless sterotype behaviour may develop. A full blown amphetamine psychotic state closely resembles paranoid schizophrenia.

Snorting of cocaine may result in perforation of the nasal septum.

Tolerance and dependence

Tolerance does develop to a certain extent. For a long time, it was not clear as to whether stimulants produced physical dependence. But now it is clearly known that it does to an extent. As the intensity of the pleasurable effects are high, strong psychological dependence also develops.

Withdrawal symptoms

When chronic use is abruptly discontinued, withdrawal symptoms occur. However, the clinical picture does not include major grossly observable physiological disruptions. Extreme fatigue, prolonged but disturbed sleep, voracious appetite, irritability and moderate to severe depression are the commonly reported withdrawal symptoms.

Depressants

Depressants are drugs which depress or slow down the functions of the central nervous system. The drugs which come under this category include:

1. Sedative-hypnotics
2. Alcohol*

Sedative-hypnotics

Sedative-hypnotics are non-narcotic depressant drugs whose primary effects are calming, sedation or inducing of sleep. Barbiturates and benzodiazipines are two main drugs that fall into this category.

Barbiturates

More than 2500 barbiturates have been synthesized and about 50 compounds marketed. These compounds have been researched and developed for their tranquilising and sleep inducing effects. Some of the more commonly used barbiturates are listed in the table below:

Generic Name	Trade Name
Thiopental	Sodium pentothal
Pentobarbital	Nembutal
Secobarbital	Seconal
Phenobarbital	Luminal Gardinal
Secobarbital & Amylobarbital	Vesparax

Barbiturates are medically prescribed for sedation and to induce sleep. They are also used for narcoanalysis (truth-serum) and as anti-convulsants (anti-seizure, e.g. phenobarbital).

Salts of barbiturates are white bitter powders.

Routes of administration

Barbiturates are administered orally in the form of tablets or capsules. Barbiturates can also be injected — subcutaneously, intravenously or intramuscularly.

* For details about alcohol refer to the chapter on 'Alcohol'.

Benzodiazepines

Over 2000 types of benzodiazepines have been synthesised but only twelve of them are marketed. Benzodiazepines as a class are the most frequently prescribed drugs. The following table lists some of the most commonly prescribed benzodiazepines.

Generic Name	Trade Name
Diazepam	Valium, Calmpose
Chlordiazepoxide	Librium
Flurazepam	Dalmane
Alprazolam	Alprax
Lorazepam	Ativan

Benzodiazepines are clinically used to reduce anxiety, induce sleep and for muscle relaxation. These are also used as pre-anaesthetic medications and to control seizures. Of late, however, physicians have been discouraged from prescribing these drugs for anxiety arising out of everyday living. The use of tranquilisers on a daily basis for more than three months is becoming less acceptable.

Benzodiazepines are white or pale yellow crystalline powders.

Routes of administration

Benzodiazepines are taken in the form of tablets or capsules. Diazepam and chlordiazepoxide are also injected intravenously.

Drugs like meprobamate (e.g. equanil), glutethimide (e.g. doriden), chloral hydrate (e.g. mickefinn drops) do not fall into either of the two categories mentioned above. But the overall depressant effects produced are similar. Methaqualone preparations (e.g. Mandrax), are sedative hypnotics that have been banned and are no longer used medically.

Short-term effects of depressants

Sedative hypnotics produce effects that are similar to that of alcohol. The main effects include:

— relief from anxiety and tension
— euphoria (usually with barbiturates)
— mild release from inhibitions
— sedation, sleep with larger doses
— poor motor coordination (especially for fine motor tasks)

— impaired concentration and judgement
— slurred speech and blurred vision

Nausea, abdominal pain, excitation which may lead to hostile behaviour can also occur.

With large doses, barbiturates can cause irregular breathing, weak pulse, coma and death. Death due to overdosage rarely occurs with other sedative hypnotics. Death due to overdosage usually occur with a combination of sedative hypnotics and alcohol.

Long-term effects

Long-term use can produce depression, chronic fatigue, respiratory impairments, impaired sexual function, decreased attention span, poor memory and judgement. Chronic sleep problems may develop. Reduced REM sleep due to drug use makes the quality of sleep so poor that the user does not feel rested on waking up.

Tolerance and dependence

Tolerance does not develop uniformly in all the drug-induced effects. With barbiturates, tolerance to the sleep inducing effects develop very rapidly often within a week or two of regular use. In the case of benzodiazepines, with chronic use, tolerance develops to the anxiety and tension relieving effects.

The user increases the daily dose to maintain the sought after effects.

Cross tolerance to other drugs of the depressant class also develops (i.e. the desired effect will not be felt, if the user who is tolerant to one of these drugs ingests another at a dose level which would otherwise be sufficient to produce the same effect).

Tolerance diminishes following a short period of abstinence.

Physical dependence can develop with regular use.

However, the psychological dependence produced is significant.

Anxiety or even panic is evident if the user is temporarily unable to obtain supply of the drug. The user experiences a persistent craving for the drug even when significant psychoactive effects are not felt.

Withdrawal symptoms:

The withdrawal symptoms after abrupt abstinence are often not as severe as withdrawal from other classes of drugs.

Mild withdrawal symptoms like anxiety, insomnia, weakness and nausea are usually noticed.

With very high and chronic use of the drug, agitation, high body temperature, delirium, hallucinations and convulsions develop.

Hallucinogens

Hallucinogens are drugs which dramatically affect perception, emotions and mental processes. As they distort the perception of objective reality and produce hallucinations, these are known as 'hallucinogens'. Hallucinogens are also referred to as 'psychedelic' (mind altering) drugs.

Hallucinogens include a wide variety of substances ranging from wholly synthetic products to naturally occurring substances. Hallucinogenic drugs are very rarely available in India, making it the least abused class of drugs. The most common hallucinogenic drugs are listed below:

LSD (Lysergic acid diethylamide)

LSD is a semi-synthetic drug and the most powerful hallucinogen. It is produced from lysergic acid, a substance derived from the ergot fungus which grows on rye, or from lysergic acid amide, a chemical found in morning glory seeds.

LSD was used only as a research tool to study the mechanism of mental illness. LSD has no medical use.

LSD is a white odourless crystalline material which is soluble in water.

Routes of administration

It is easily absorbed orally and is usually taken in the form of tablets. LSD blotter papers are also common. Here LSD is dissolved in water and is absorbed in blotting paper. A piece of this paper is torn off, placed under the tongue and sucked.

PCP (Phencyclidine)

PCP was synthesised and tested as a human anaesthetic in the 1950's. Its use was later discontinued due to its side effects that included confusion and delirium. It later came to be used in veterinary medicine. PCP is now produced only in clandestine laboratories.

PCP is commonly called 'angel-dust'. PCP in its pure form is a white crystalline powder that readily dissolves in water.

Routes of administration:

It is snorted, smoked, eaten and rarely taken intravenously.

Mescaline:

Mescaline is derived from the 'Mexican peyote cactus' and the 'San Perdo cactus'. For centuries consumption of mescaline was part of religious ceremonies in parts of North America. It is still used in these areas. Mescaline can also be produced synthetically.

Mescaline appears as a white or coloured powder.

Routes of administration

The oral route of administration is most common.

Psilocybin

Psilocybin is chiefly derived from the 'psilocybe' mushroom. The drug can be synthetically produced only with great difficulty. Crude mushroom preparations containing psilocybin are usually sold as dried brown mushrooms.

Routes of administration

This drug is well absorbed orally. The mushroom itself may be eaten or dried, powdered and smoked.

DMT (dimethyl-triptamine), DOM (4 methyl-2, 5 dimethoxy-amphetamine), MDA (methylenedioxyamphetamine) and belladona in alkaloids also come under the hallucinogen category of drugs.

Short-term effects of hallucinogens

The physical effects produced and perceptual effects created differ from one drug to another and wide chemical differences also exist. The main effects include:

- Alterations of mood — usually euphoric but sometimes severely depressive.
- Distortion of the sense of direction, distance and time (e.g. passage of a few minutes may seem like hours).
- Intensification of sense of vision. Colour and texture of items become more vivid and perception of details is increased.
- 'Psuedo' hallucinations ('pseudo' because the user knows that the experience is not true. e.g. seeing a myriad of colurs or bizarre images).
- Synesthesia (melding of two sensory modalities). [User may feel he can see music, hear colours etc.]
- Feelings of depersonalisation, loss of body image and a loss of sense of reality (the user may feel that his body is shrinking or becoming weightless).
- Sense of past, present and future may be jumbled. Concentration becomes difficult and attention fluctuates rapidly.
- Vague ideas and extreme preoccupation with philosophical issues is common. The great truths and insights he believes that he discovers are unintelligible or nonsensical to those not under the influence of LSD.

Hallucinogens are however unpredictable in their effects each time they are used. Acute panic reactions can also be produced resulting in a 'bad trip'. Acute anxiety, restlessness and sleeplessness are common until the effect of the drug wears off.

Self destructive behaviour and rash decisions and accidents springing from impaired judgement are common.

Long-term effects

— '**Flashbacks**' or spontaneous recurrences of an LSD experience can occur without warning for upto a year after LSD use. The exact mechanism of this effect is not known. The user may experience effects such as intensification of colour, apparent movement of a fixed object or other hallucinogenic effects even after abstinence for a few months.

— **Amotivational syndrome:** The user becomes very apathetic, is very passive and shows no interest in life.

— **LSD precipitated psychosis:** Acute panic reactions which can occur may lead the user into a stage of drug-induced psychosis. It may resemble paranoid schizophrenia in many respects with hallucinations (mainly visual), delusional thinking and bizarre behaviour. The psychotic episode normally lasts for several hours but in some cases it may last for years.

Tolerance and dependence

Tolerance develops very quickly and disappears rapidly after discontinuation. Due to rapid development of tolerance, most of the users discontinue use of the drug atleast for a while, to regain original sensitivity.

Psychological dependence develops though the user does not become physically dependent. Particular withdrawal symptoms are not reported.

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CANNABIS

Cannabis drugs are made from the Indian hemp plant — Cannabis Sativa. This plant has been cultivated for centuries in many parts of the world for the tough fibre of the stem and for its psycho-active properties. When its mind altering properties came to light, the cultivation of cannabis was banned. Its therapeutic potential and possible medicinal properties were and are being studied. As of now, cannabis drugs do not have any medical use.

More than 60 constituents, known as cannabinoids, occur naturally in and only in the cannabis plant. The chief psychoactive substance in them is delta-9-tetra-hydrocannabinol — commonly referred to as THC. THC is responsible for the effects that the cannabis drugs produce. THC can be produced synthetically but only at a considerable cost and effort.

The main drugs under this category include:

Ganja/Marijuana

Ganja is prepared from the dried leaves and flowering tops of the plant. Ganja is commonly referred to as grass, pot or stuff.

The concentration of THC in ganja varies widely depending on the source and selectivity of plant materials used.

Ganja may range in colour from greyish green to greenish brown and in texture from a dry leafy material to a finely divided tea like substance.

Ganja is usually smoked in the form of hand-rolled cigarettes ('joints' or 'reefers') or pipes specially made for this purpose. Ganja is usually mixed with tobacco and smoked. The proportion of ganja and tobacco is altered according to the need of the user.

Hashish/Charas

Both male and female forms of the cannabis plant exist. The female plant secretes a sticky resin which has a high THC concentration. The resinous secretion of the cannabis plant, which is collected and dried is known as Hashish/Charas.

The THC content in hashish ranges from 5-15%.

Hashish sometimes contains the dried compressed flowers and ranges in colour from light brown to almost black.

Hashish can be smoked and is sometimes baked with food and eaten.

Hashish Oil

Hashish oil is produced by a process of repeated extraction of cannabis plant material to get a high concentration of THC. It is highly potent with a THC concentration ranging from 20% upto even 60%. A drop or two of this liquid is equivalent to one or more 'joints' of ganja in terms of its psychoactive effects.

Hashish oil is a dark viscous liquid. It is usually dripped on cigarettes and smoked.

Bhang

This is the least potent of all cannabis drugs. Bhang contains the dried parts of the plants — leaves and stem.

Bhang is a brown leafy material with dried twigs. Bhang is usually brewed with tea or milk and drunk.

Pharmacology of Cannabis Drugs

Absorption

When cannabis drugs are smoked, less than 50% of the THC is absorbed and enters the blood circulation. The effects are felt within minutes. The effects peak after 10-30 minutes and action ceases after 2-3 hours.

When taken by the oral route, the effects are felt after 1 hour and the peak is reached only after 4-5 hours. Users prefer to smoke the drug, as it is about three times more potent when compared to the oral route of administration.

Distribution

After absorption, THC rapidly leaves the blood and enters the body organs. THC is not distributed evenly throughout the body and concentrates especially in the fat tissues. As it is highly fat soluble, it enters the brain also. The absorbed THC stays in the brain, reproductive organs and fat tissues for long periods of time as it undergoes no breakdown in these tissues.

Excretion

THC rapidly enters the fat tissues from the blood. From here they must pass back to the blood and reach the liver to get metabolised.

THC is metabolised by the liver into more water soluble compounds so that it can be excreted. Some of the metabolites (products of metabolism) which are produced are also psychoactive.

Effects on the user

The exact effect that cannabis drugs produce cannot be accurately predicted. The prior experiences and expectation of the user, the potency of the drug etc., are important factors that produce the psychoactive effect. The main effects include:

- mild euphoria followed by a dreamy state of relaxation
- increased auditory and visual acuity (e.g. sound seems louder and clearer, vision seems brighter and sharper)
- sense of smell, touch and taste are often enhanced
- lowering of inhibitions, spontaneous laughter
- altered sense of time perception (e.g. time seems to pass more slowly)
- impaired short-term memory, reduced attention span, poor concentration and disturbed thought patterns
- impairment of ability to perform complex motor tasks
- decreased muscle strength
- splitting of consciousness is evident. The user experiences the 'high', while at the same time becomes an objective observer of his own intoxication. He may have paranoid thoughts, and yet simultaneously laugh at them.

Some users experience a 'bad trip' which includes adverse reactions like mild paranoia, fear, anxiety, or even panic. Nausea, vomiting and dizziness may occur.

In addition to the above effects on the central nervous system, the following effects are also noticed:

Cardiovascular

— Tachycardia (increased heart beat) is very prominent
— Slight drop in body temperature and blood pressure causing dilation of blood vessels. Due to the dilation of the conjunctiva, reddening of the eyes can be noticed.

Respiratory

Irritation of the mucosal membranes lining the respiratory system; bronchodilation.

Gastro-intestinal

Increased appetite, especially for sweets; dryness of the mouth and throat due to decreased salivary flow.

Other effects

— Suppression of REM sleep

Higher doses intensify reactions. The individual may experience shifting sensory images, mood swings, a flight of fragmentary thoughts, an altered sense of self-identity, impaired memory and lack of attention despite an illusion of heightened insight. Confusion about the past, present and future and hallucinations may also develop. Very high doses may result in toxic psychosis.

Tolerance and dependence

Frequent and regular users of high doses develop tolerance to the drug. To maintain intensity of effects, users increase their daily dose. Original sensitivity can be restored with abstinence for several days.

Physical dependence on cannabis develops only in high dose users. Strong psychological dependence develops with the regular user. User acquires a persistent craving for the drug which consequently takes on a central role in his life. Even if cannabis is temporarily unavailable, anxiety or feelings of panic may ensue.

Withdrawal symptoms

Abrupt cessation of cannabis use leads to withdrawal symptoms — sleep disturbances (sometimes with recurrent nightmares), loss of appetite, irritability, nervousness, anxiety, sweating and an upset stomach. Sometimes chills, increased body temperature and tremors develop. Withdrawal symptoms usually last for less than a week.

Complications

— Pronounced psychological dependence is particularly high among users with emotional problems who turn to cannabis for relief from psychological stress. They may come to depend inappropriately on cannabis instead of learning a drug-free means of coping with stress.

— Amotivational syndrome: The user may lose all interest in his work, family etc. He may become so apathetic that he may not even respond when his name is called out.

— Psychosis: A typical psychotic episode characterised by confusion, delusion, hallucinations, disorientation and paranoid symptoms may develop.

— Frequent long-term cannabis use may produce bronchitis, asthma, sinusitis, or chronic redness of the eyes because of its irritant effect.

— Sterility: There is evidence to indicate that prolonged use can cause reduced sperm-count and decreased sperm motility.

Ongoing studies have revealed some evidence to show that cannabis use reduces the immunity by impairing a component of the white blood cell defense system. It is also speculated that smoke from cannabis increases the risk of cancer.

Medical management

There is no specific medical treatment for cannabis abuse. If the person uses the substance for anxiety reduction or for the alleviation of depression, an anti-anxiety agent or anti-depressant should be considered as substitution therapy. For an acute anxiety reaction, the drug diazepam is useful. For any psychotic problems detected, major tranquilisers should be used.

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3
HEROIN

Heroin belongs to the category of narcotic analgesics and is a semi-synthetic derivative of the drug morphine. Brown sugar is an adulterated form of the drug heroin.

When heroin (diacetyl morphine) was first synthesized, medical men thought they had an effective painkiller on their hands. Years later, when the negative side effects and high addictive properties were identified, it was banned. Heroin has no medical use whatsoever.

Pure heroin is a white crystalline powder with a bitter taste and is a costly drug by Indian standards. To increase the marketability of the drug, an adulterated variety came into the market. Cleaning powder, quinine, starch, maltose, agarbatti ash, chuna, datura and even soap nut powder are added to heroin to increase the bulk of the drug. Due to the adulterants added, the drug's colour varies from light to dark brown. This is referred to as 'brown sugar' or 'smack'. Purity of the brown sugar sold on the streets varies widely. Diluents are mixed with heroin in ratios ranging from 9 to 1 to as much as 99 to 1.

Routes of administration

Injected

The drug is dissolved in water and injected subcutaneously or intravenously. When injected, 'the rush' (heightened pleasure) experienced is magnified. But heroin does not dissolve completely in water and some of it is wasted.

Heroin is rarely snorted.

Inhalation

Smoked with tobacco in cigarettes or 'chased'.

Chasing: The drug is sprinkled on a silver foil or placed in a bent spoon and heated from beneath with a candle. The thick fumes which arise are taken in through the mouth with a rolled up piece of paper.

'Chasing' is the method most commonly used to take brown sugar while users of heroin generally prefer to inject the drug.

In general, brown sugar is not taken orally. Narcotic analgesics, being alkaline in nature, are not absorbed in the acidic medium of the stomach. In the intestine, the heroin molecules quickly conjugate (attach) to other molecules, making absorption difficult. The little that gets absorbed must pass through the liver before getting into the bloodstream. The liver quickly destroys the drug thereby drastically reducing its potency. It is estimated that about 90% of the effect is lost when taken orally.

Metabolism

Distribution

Brown sugar is not absorbed evenly by all the parts of the body. It concentrates in the tissues especially in the kidneys, liver, skeletal muscle, lungs and spleen. Only small amounts of narcotic analgesics cross the blood brain barrier* (BBB) but the central nervous system is so sensitive that even minute amounts are sufficient to cause a pharmacological effect.

Small quantities of the drug cross the placental barrier, and fetal dependency can develop.

* The brain is surrounded by several membranes and blood vessels which supply blood to the brain. These form a barrier around the brain which is selective as to what can cross over into the brain tissue from the main blood circulation. This is called the blood brain barrier.

Excretion

Excretion of narcotic analgesics is largely through the urine after metabolism to water soluble metabolites (products formed due to chemical reaction in the body). A little amount passes through the lungs and bile.

Pharmacology

There are specific receptor sites on cell membranes in the brain and other places in the body. In our body we have endorphins and enkephalins which are involved in the regulation of pain perception and the emotional response to it.

Narcotic drugs bind with enkephalin receptors in the body and produce the same effect. When high doses of narcotics are taken, the normal body production of enkephalin and endorphin is decreased. When narcotic administration is stopped, the body goes through a period of re-adjustment until the body's own enkephalin production returns to normal — this is the withdrawal period.

Short-term effects

Analgesia, drowsiness, mood changes and mental clouding are the main effects. Other manifestations are a feeling of warmth, heaviness of extremities and dryness of the mouth. The face becomes flushed due to the release of histamine. Among the intravenous users, an immediate high (rush), described as akin to an orgasm is reported. This is followed by sedation.

Effects produced by brown sugar are similar to those of morphine. But its analgesic property is three times more potent and it is also felt much faster as it reaches the brain quicker.

Other physical signs and symptoms include constipation, muscular impairment, tremors of the tongue, face and hands, and pin point pupils (pupils are maximally constricted so that they cannot constrict any further in response to light).

As the dependence increases, a progressive deterioration in general health occurs. The victim becomes dull, apathetic, anaemic, haggard and eachetic (malnourished), losing interest in himself and his environment. His intellectual faculties are impaired, and his sense of moral values warped.

System effects

CNS (Central Nervous System) effects

— Euphoria
— Analgesia
— Drowsy, dreamy, mild dozing state. In some, excitation may be noticed
— Apathy, decreased physical activity, inability to concentrate

— Pin-point pupils, droopy eye-lids, reduced visual acuity
— Vomiting in novice users due to stimulation of the chemotrigger receptor zone in the brain (area in the brain which controls vomiting or the vomiting centre)
— Decrease in REM sleep (rapid eye movement — the rapid, jerky movements of the eye which occur during certain stages of the sleep cycle when dreams occur). The REM stage of the sleep cycle is most beneficial to the body as the body is most relaxed at that time. Brown sugar causes drowsiness but decreases sleep time and decreases REM sleep.

Respiratory system

— Depression of respiration due to the effect on the respiratory centre in the brain stem.

Cardio-Vascular system

— Bradycardia or decrease in the heart rate
— Dilation of peripheral blood vessels, which is the cause of flushing
— Hypotension or low blood pressure

Gastro Intestinal tract

— Constipation and poor appetite.

Kidneys

— Mild decrease in urine formation due to increased secretion of the ADH (anti-diuretic hormone).

Other adverse reactions

When an individual takes brown sugar, his experiences are not always pleasurable. The adverse reactions that occur usually are:

— Nausea, vomiting
— Mental clouding; dizziness
— Dysphoria or a feeling of unpleasantness
— Severe constipation
— Allergic reactions (manifested as hives which can appear at or near the injection sites due to release of histamine in the body).

Long-term effects

Mood instability, reduced libido, constipation, pupilary constriction (which affects night vision) and certain types of respiratory impairments can develop. In female drug users, menstrual irregularity usually occurs.

In addition, the following complications can develop.

- Serum hepatitis which is caused by use of infected needles
- AIDS (acquired immunedeficiency syndrome) may occur due to use of infected needles or sharing of needles
- Complications due to the presence of adulterants like quinine, datura etc in brown sugar
- Perforation of nasal septum if the route of administration has been snorting
- Fetal addiction can develop. 80% of the babies born to addicted mothers develop withdrawal symptoms such as hyper activity, irritability, tremors, regurgitation, poor feeding and diarrhoea. Convulsions may also occur. These children usually have low birth weights.

Severe overdose of heroin results in very slow, shallow, irregular breathing, marked decrease in blood pressure, cyanosis and coma. Death usually results from respiratory arrest or other respiratory or cardio-vascular complications.

Tolerance and dependence

Increasingly higher doses are required to produce satisfactory analgesic, sedative and euphoric effects. Tolerance also develops to its respiratory-depressant and nausea inducing effects. However, tolerance does not develop to the pupilary constricting or constipating effects.

As tolerance develops with chronic use, and the user gradually increases the dose to achieve the desired effect, a dose plateau is reached where no amount of the drug is sufficient to produce the intensity of effects desired. The user, however, continues the use of the drug to delay withdrawal symptoms.

Powerful physical and psychological dependence develops with brown sugar abuse. Abrupt cessation of the drug use leads to withdrawal symptoms.

Withdrawal symptoms

The severity of withdrawal symptoms will depend on a number of factors like the duration of drug abuse, typical daily dosage and the general health condition of the person.

Withdrawal symptoms appear between 8 and 12 hours after the last dose. Symptoms include:

Excessive lacrimation (watering of eyes), coryza with rhinorrhoea (running nose), yawning, sweating, and increased salivation. This stage is followed by an agitated sleep referred to as the 'YEN' sleep which may last for several hours. Upon wakening, agitation accompanied by depression continues. Loss of appetite, dilated pupils, tremors, piloerection (goose flesh which forms the basis of the expression "cold turkey") are the other symptoms.

Withdrawal symptoms peak between 36 and 72 hours. There are usually alternations between bouts of chills and shivering and bouts of flushing and excessive sweating. Goose flesh is highly prominent. Uncontrollable yawning, vomiting, nausea, diarrhoea, abdominal cramps, pain in the bone and muscles, muscle spasms and uncontrollable kicking movements (which gave rise to the term 'kicking the habit') are also experienced.

Increased irritability, restlessness, severe agitation, insomnia, emotional depression can be noticed. Generalised hyperaesthesia (increased sensitivity to touch of tactile stimuli), paraesthesia (distorted perception of tactile stimuli), neuralgic pains (excruciating pains in extremities), clouded consciousness and delirium can also occur.

Cardio-vascular instability giving rise to hypertension and tachycardia (increased heart rate), increased blood pressure, and general weakness are also noticed.

Long after the observable physical symptoms of withdrawal disappear, a psychological craving for the drug persists. Chronic depression, and period of agitation may last for extended intervals of time.

The main withdrawal symptoms of heroin are presented below in the form of a table:

Symptoms	Time in hours
Craving for drugs, anxiety	4
Yawning, perspiration, running nose, tears	8
Pupil dilation, goose pimples, muscle twitches, aching bones and muscles, hot and cold flashes, loss of appetite	12
Increased intensity of the above, insomnia, raised blood pressure, fever, faster pulse, nausea	18 to 24
Increased intensity of the above, curled-up position, vomiting, diarrhoea, increased blood sugar, kicking movements	26 to 36

Medical management

Brown sugar dependents suffer from a complex combination of medical and psycho-social problems. Consequently, multiple treatment methodologies are often used for these patients. Several treatment approaches are used simultaneously or sequentially.

Detoxification

This is the first step in a long term treatment programme. This simply means withdrawing the drug upon which the person is dependent and making the withdrawal period more comfortable with medication.

Withdrawal from brown sugar is quite painful and unpleasant and, without medical help, the user may become prone to suicide. The user may become agitated and violent during withdrawal. Sedatives, tranquilisers, analgesics, anti-diarrhoeals are usually used during the withdrawal period to make the patient feel somewhat comfortable.

Narcotic withdrawal is usually not life threatening, although a marked electrolyte imbalance caused by excessive vomiting and diarrhoea must be watched.

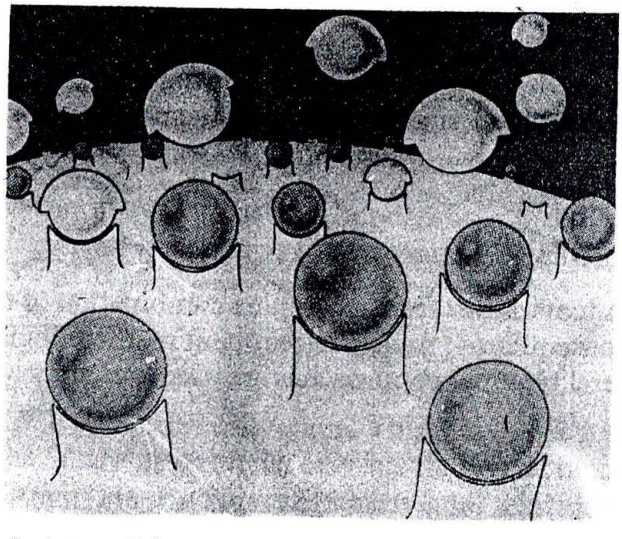
For those patients with psychiatric disorders in addition to substance abuse, specific treatment is required. Failure to attend to these psychiatric problems will result in a relapse.

Clonidine is a drug often used to handle the withdrawal symptoms of brown sugar. It is not a narcotic drug, but it relieves many of the symptoms of opiate withdrawal, particularly those which involve physical symptoms of the autonomic nervous system hyper-activity. It is an adrenergic agonist and inhibits the activity of neurons in the locus ceruleus, which may explain its ability to block the withdrawal symptoms.

Clonidine does not produce euphoria and it is also not an addictive drug.

Narcotic antagonist drugs

Use of narcotic antagonists like Naltrexone is becoming a part of the treatment programme for heroin dependency. Narcotic antagonists are drugs which block or reverse the effects of narcotics. The main effect of this antagonist is to occupy opiate receptors and prevent opiate drugs from exerting any effect like euphoria. As they compete for the same receptor site, if narcotics are already on the receptors, naltrexone can displace them, reversing the effect and causing narcotic withdrawal.



Mechanism of action of naltrexone. Naltrexone occupies the opioid receptor sites in the brain, thereby antagonizing the analgesic, euphoric, and other psychotropic effects produced by large doses of narcotics, such as heroin.

Naltrexone is being tried as part of the after-care therapy for heroin dependency. This drug is not a treatment by itself but it has been found to be effective within the context of a comprehensive rehabilitation programme for prevention of relapse.

After treatment, the addict is given naltrexone on a regular basis (sometimes as infrequently as two to three times a week). If a person on naltrexone takes brown sugar, he will not experience any of the 'sought effects'. Thus this medication will provide protection against re-addiction, should the person impulsively take a dose of brown sugar.

Methadone

Methadone is a substitute drug used in the treatment of narcotic analgesic dependency. Methadone is a synthetic narcotic with a long duration of action. Methadone is usually administered orally in the form of tablets.

Methadone fully blocks withdrawal which would naturally occur on abrupt cessation of narcotic use making 'cold-turkey' a less painful condition. Thus, methadone is sometimes used to make withdrawal more comfortable.

Methadone maintenance programmes were initiated to reduce relapse rates with narcotic dependents. Heroin addicts were put on regular doses of methadone. This therapy was effective in reducing the 'drug-hunger' without producing the much sought after effects of euphoria or sedation.

Initially, methadone was shown to decrease relapse rates and methadone clinics were opened in many parts of United States.

Later methadone was also found to be abused. Moreover, methadone maintenance also resulted in physical dependence and exacerbated hypophobia when methadone treatment was discontinued (Martin et al 1973). The resultant negative mood state sometimes persisted for many months after detoxification. In view of these developments, most methadone clinics were closed down.

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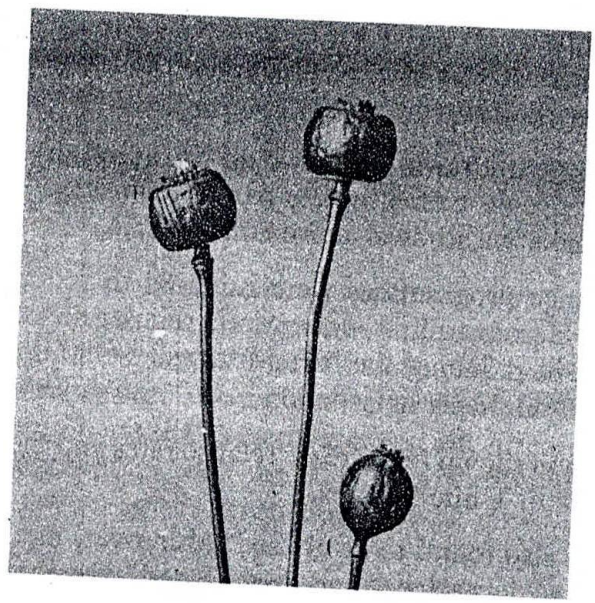
4
OPIUM



The word 'opium' is derived from the Greek word, 'opion' meaning 'poppy juice'. Opium is obtained from the poppy plant 'Papaver Somniferum'. The poppy plant has been cultivated for centuries in many parts of the world for its pleasurable and a few medicinal effects.

Opium belongs to the category of narcotic analgesics and is the main source of non-synthetic narcotic drugs.

The poppy plant grows to about one metre in height. Its leaves are oblong and its flowers are white, purple or red in colour. Several days after the poppy's petals fall, a greenish pod, two inches long and about two inches wide, is formed. While it is still unripe, incisions are made on the pod. This is a delicate hand operation, that requires skill to ensure that the pod is not punctured. The milky juice which exudes from the cut, coagulates on exposure to air. This is carefully scraped by hand and dried in the shade for several days. This product is called opium.

Cheap labour is one of the important prerequisites for successful opium cultivation. (It is estimated that the collection of 1 kg of opium requires approximately 280 hours of labour.)

Countries of Asia Minor, Turkey, and the Far East remain the primary source of both illegal and legal opium cultivation and trade. In India, opium is largely cultivated in Madhya Pradesh, Rajasthan and Uttar Pradesh. Many control measures have been enforced in the area of poppy cultivation. The poppy plant can now be cultivated only with a licence from the Narcotics Wing of the Excise Department and the produce can be sold only to the Government. Unfortunately, certain quantities are diverted from the legally cultivated plants. Poppy plants are also grown illegally.

Opium was traditionally used in mid and far eastern areas such as Iran, Thailand, Hongkong, Phillipines, China and India for hundreds of years. In India, opium is still commonly used in western Rajasthan, parts of Punjab and Haryana. Opium use is culturally sanctioned and is a socially acceptable practice. In many rural communities, opium is often served to visitors as a mark of their hospitality.

Opium is a dark brownish or a dark greyish tar-like substance with a musty odour. Opium is usually sold in the form of small balls, lumps or bricks.

Routes of administration

Opium is primarily taken in orally. The dried opium is usually boiled in water and the solution is drunk. Ingestion is a relatively inefficient route of administration and the effects felt are only mild.

Opium is sometimes mixed with tobacco, chewed and then kept in the mouth. The absorption of the drug takes place through the mucous membranes of the oral cavity.

Opium can also be smoked. Opium smokers increase the purity of the crude susbstance, by boiling it in water and filtering it several times till it becomes a sticky paste. This paste is then dried and smoked.

The infamous 'opium dens' of the yesteryears are non-existent today. Opium is now smoked alone or in groups in their own houses. Opium smoking has declined considerably because it has to be done entirely surreptitiously due to the noticeable odour of opium. A special piece of equipment, (sometimes simple but generally elaborate) is used by opium smokers. Opium is smoked in the lying down posture to reduce the feelings of nausea.

Short-term effects

Opium contains a number of naturally occurring alkaloids. Morphine is the principal alkaloid present in opium and ranges in concentration from 4 — 21%. The bulk of the remaining quantity consists of a variety of substances which have little or no pharmacologial effect.

The main effects of opium include:

— A feeling of euphoria
— Drowsiness, lethargy, a feeling of relaxation
— Decreased physical activity in some and increased physical activity in others
— Difficulty in concentration

Nausea, vomiting, constipation, loss of appetite and pupilary constriction are some of the unpleasant side-effects.

Long-term effects

Among long-term users, mood instability, impaired night vision, constipation and reduced libido usually develop.

Tolerance and Dependence

With protracted heavy use, tolerance develops necessitating increased quantity of drug intake.

Physical and psychological dependence develop in the regular high dose user.

Withdrawal symptoms are virtually identical to those of brown sugar. Watery eyes, nasal discharge, uncontrollable yawning, sweating, agitated sleep, nausea, vomiting, excessive weakness, severe aches and pains in the muscles and joints, and stomach cramps appear. Depression, irritability, periods of agitation, loss of appetite and continued craving which point to the psychological dependenc on the drug are also reported.

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5

ALCOHOL

What is Alcohol?

The word 'Alcohol' is derived from the Arabian term, 'al-kuhul' which means 'finely divided spirit'. There are many types of alcohol — amyl, butyl, isopropyl, isobutyl, methyl, ethyl alcohol, etc. Different types of alcohol have various industrial and chemical uses.

Ethyl alcohol (Ethanol) is what is commonly consumed. In this chapter, we are going to talk only about Ethanol therefore when 'alcohol' is mentioned hereafter, it will refer to Ethanol.

Alcohol is a clear, thin, highly volatile liquid, with a harsh burning taste.

There are various processes by which alcohol is obtained. They are:

Fermentation

Alcohol is the product of a natural process called fermentation. If the juice of certain fruits or vegetables is left in the open air, this process will begin. A microscopic plant called yeast floats freely and reacts with the sugar in the juice. This reaction produces alcohol and releases carbon dioxide in the air.

Distillation

To make beverages with higher alcohol content, a process called distillation is used. Distillation is the heating of a liquid until it turns into a vapour and then condensing it into a liquid again. When wine or beer is heated in a 'still' (vessel used for distillation) to 173°F, the alcohol boils off as a vapour and the water and most of the other ingredients of the wine or beer remain in the still. The vapour is then cooled. It becomes a liquid which is almost pure alcohol. The distillation process is used to make alcoholic beverages that contain 40 - 60% alcohol. They are called distilled spirit (e.g. Whisky, Gin, Rum etc).

Colouring, flavouring and other constituents called congeners are added during its commercial preparation.

The alcohol content and the source of some alcoholic beverages are given below:

Name of the beverage	Source	Approximate Percentage of alcohol
Brandy	Distilled Wine	40 - 50%
Whisky	Cereals	40 - 55%
Rum	Sugar Cane (Molasses)	40 - 55%
Wines (Port, sherry, Champagne, etc)	Grapes	10 - 22%
Beer	Cereals (Barley)	6 - 8%
Toddy	Palm juice	5 - 10%
Arrack	Molasses	50 - 60%

Before proceeding further, let us understand what ONE DRINK implies:

1 Drink or 10 grams of alcohol

Whisky, Brandy, Rum	Wine	Toddy, Beer
30 ml	60 ml	285 ml
(1 oz)	(2 oz)	(10 oz)

Factors influencing the effects of alcohol

The effects of alcohol are directly related to its concentration in the blood (Blood Alcohol Level). Alcohol acts directly on the brain and changes its working ability. The effects depend on the speed at which the person drinks, his weight, presence of food in the stomach, and the type of beverage taken. The effects of alcohol on an individual also depend on a variety of other factors like the situation, one's attitude to drinking and one's drinking experience.

Here are a few factors

Speed of drinking

The more rapidly an alcoholic beverage is taken, the higher will be the blood alcohol concentration (BAC).

Body weight of the drinker

The greater the weight of a person, the lower will be his BAC. Because of the way alcohol circulates in the body fluid, the weight of the drinker is also a factor related to the effect of alcohol. For instance, a person weighing 80 kilos will not feel the effects of one glass of whisky as much as a person weighing 50 kilos.

Presence of food in the stomach

Food in the stomach slows down the rate of absorption. A drink after eating a meal will have less effect than if it is taken on an empty stomach.

Type of alcoholic beverage

The basic ingredient in all major alcoholic beverages is Ethyl Alcohol. Some beverages have more alcohol content in them than others. For example beer has 6 — 8% alcohol whereas distilled spirits have 40 — 60%. A person consuming a beverage with a higher alcohol content will experience its effects much more than a person taking a drink with a lower alcohol content.

Situation

Behaviour gets regulated when one is drinking, depending on where he is and whom he is with. A young person having dinner with a friend may feel slightly 'high' after one drink. If he has dinner with his boss the next night, one drink may not have any effect at all. Here we find the individual regulating or closely monitoring his behaviour.

Drinking experience

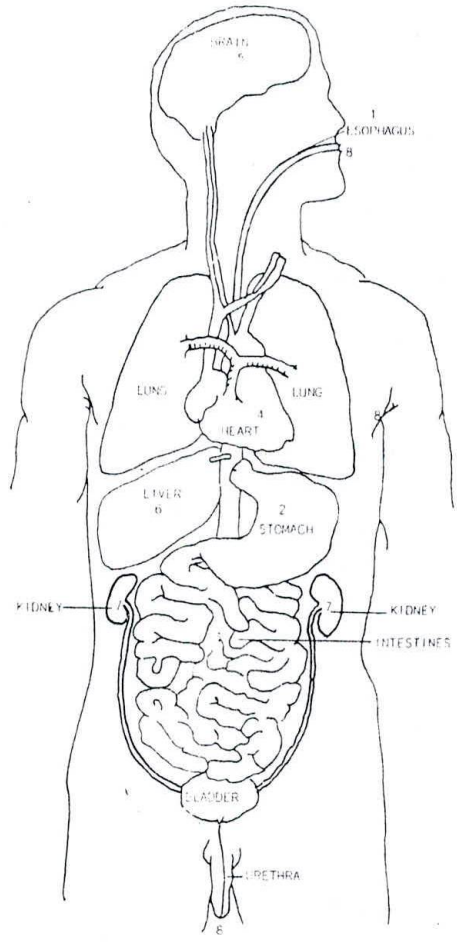
Those who are used to alcohol, recognise when it is beginning to interfere with their judgment and coordination. Certain reactions warn them as to when to stop drinking and when to control their behaviour.

Inexperienced drinkers do not have a clear picture of how they will react to alcohol; nor have they learnt to control their reactions. In fact, since they are expecting something to happen, they may purposely behave with less control. They may also be unsure of when to stop, and may drink much more than what they can handle.

Path of alcohol in the body

What happens in reality when we drink alcohol?

How does the body deal with it?



The statement numbers are key to the diagram.

1. Alcohol is taken into the body through the **mouth** and travels to the stomach via the **esophagus**. Alcohol, in its initial state, is in a form which can be immediately used by the body.
2. In the **stomach**, chemicals are added to the alcohol. These chemicals have little effect on the alcohol. Much of the alcohol is absorbed into the bloodstream directly from the stomach.
3. The remaining alcohol travels to the **small intestine** where it is absorbed into the blood.
4. Once in the **bloodstream**, the alcohol travels to all parts of the body. It affects heart rate, blood pressure, appetite, gastric secretion, urine output, etc.
5. Alcohol also affects the **brain**, causing a variety of reactions ranging from relaxation to unconsciousness and death.
6. In the **liver**, the chemical alcohol undergoes the process of oxidation, where it is eventually changed to carbon dioxide, water and a release of energy. These chemicals re-enter the bloodstream and move on to the kidneys.
7. The **kidneys** filter out the end products of the oxidation process, which are finally excreted out of the body.
8. About 95-98% of the alcohol undergoes steps 1-7; however, the remaining 2-5% escapes unchanged via **sweat, the breath and the urine**.

Alcohol is one of the few things that is absorbed as soon as it enters the stomach.

Its molecules are small and its chemical pattern simple enough to be used for fuel almost immediately after swallowing.

Unlike other food, alcohol does not need digestion. After ingestion, it is carried to the stomach and small intestines and immediately gets across through the wall of the stomach into the blood stream, from where it is carried to almost all the organs.

As already stated, the rate of absorption is not constant, but depends on various factors like the speed of drinking, concentration of alcohol taken, the amount of foodstuff in the stomach, etc. In the liver, alcohol undergoes a process of oxidation whereby it is changed into carbon dioxide and water and finally energy is released.

Metabolism

Alcohol is used and disposed of by the body, in four phases. They are: absorption, distribution, oxidation and elimination.

Absorption

This takes place in the stomach and small intestines. It is a process whereby the thinnest of blood vessels called capillaries found in the walls of the stomach and small intestines, pick up alcohol as soon as it enters and transport it to all parts of the body.

Distribution

This is the process by which alcohol travels in the blood to each organ, tissue and cell. By simple diffusion, alcohol leaves the bloodstream and enters the cells. Alcohol then begins to affect the various organs including the brain.

Oxidation

Once alcohol is absorbed into the bloodstream and distributed throughout the body, the process of oxidation begins. The liver plays a major role in the break down or oxidation of alcohol. Alcohol is oxidised by the liver at the rate of 8 — 15 ml per hour. The oxidation process is brought about by the enzymes produced by the liver. Alcohol is first changed into Acetaldehyde, which in turn is converted to Acetate by the enzyme Aldehydrogenase. As a result of the process of oxidation, alcohol is changed into carbon dioxide, water and energy.

The energy yield of alcohol-oxidation is about seven kilo calories per gram of alcohol.

There is a mistaken notion that exercise, fresh air, cold shower, hot bath or black coffee will help in making a person sober. This is not true at all. The fact remains that these methods have no effect on the oxidation rate.

All that one can do is to wait, and let the liver do its work.

Elimination

After oxidation, these chemicals re-enter the bloodstream and move on to the kidneys. The kidneys filter out the end product of the oxidation process. They are finally excreted from the body. 95-98% of alcohol consumed undergoes the above stated changes, while the remaining 2-5% escapes unchanged through sweat, breath and urine.

Ethyl alcohol (C_2H_2OH), the intoxicating substance in alcoholic beverages, is considered a food that supplies empty calories — calories without any nutritive value whatsoever.

From the medical and psychological point of view, it is a depressant, an anti-septic, anaesthetic, and a hypnotic agent.

Alcohol is a dependency-producing, habit forming, highly addictive drug.

Alcohol is a DRUG

Even though many people are not aware it, it is an undisputed fact that alcohol is a potent drug. Ethyl alcohol (C_2H_2OH) the intoxicating substance in alcoholic beverages, produces physical and psychological changes. Therefore, alcohol is considered to be a drug. In the case of alcohol, these effects range from a feeling of well being experienced after one or two drinks, to drunkenness, which is the acute effect of having too many drinks.

Alcohol is a DEPRESSANT

Alcohol is often misunderstood as a stimulant because it appears to make people more lively and less inhibited. It is actually a **depressant**. If taken in small quantities, it **depresses** that part of the brain which controls inhibitions, and so the person feels relaxed. When blood alcohol concentration (BAC) is low, the drinker experiences a feeling of relaxation, tranquility and a sense of well being. It slightly increases the heart rate, dilates blood vessels, stimulates appetite, and moderately lowers blood pressure. When BAC is high, it depresses the other areas of the central nervous system, and this results in severe problems.

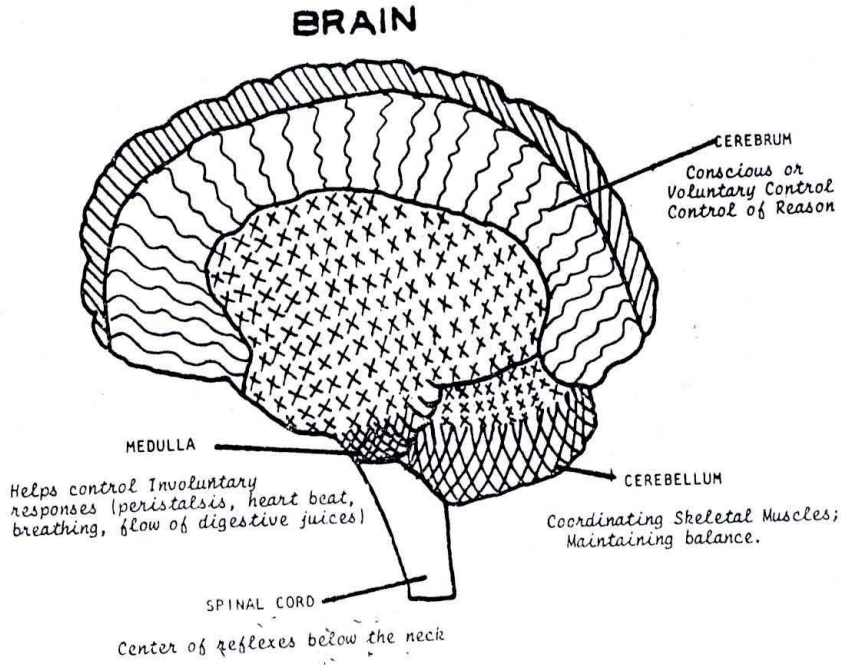
Short-term effects:

These effects appear rapidly even after small or large doses and disappear within a few hours. Alcohol affects the brain and nerve cells, which in turn affect human behaviour. The brain is highly sensitive even to very low alcohol concentrations. The disturbances which result are shown in the activities of the organs controlled by the brain.

A peculiar characteristic of alcohol is that all the nerve cells in the brain are not affected by the same BAC. Some nerve centres are more resistant than others,

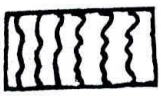
and are not affected by low BAC. For example, the first to be affected are the centres controlling the higher functions that have been learnt. These include inhibitions and judgement. It is always important to remember that the degree to which people are affected is not always reflected in their behaviour. Since people react differently to alcohol, there is no way of telling by outward behaviour as to how much of alcohol a person has consumed. It can only be approximately generalised.

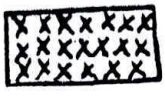
EFFECTS OF ALCOHOL ON AREAS OF THE BRAIN



Key For Brain Diagram


One to two drinks.


Three to four drinks.


Five to seven drinks.


Eight to twelve drinks.

The most predominant short-term effect of alcohol is that it temporarily removes normal inhibitions.

It also acts as a psychic anaesthetiser, temporarily erasing painful feelings of anxiety, worry, tension, hopelessness and anger.

If larger doses are ingested in a short span of time, a state of social and physical incompetence, known as drunkenness or intoxication ensues.

The following table illustrates the approximate effects produced by alcohol when a person consumes it over a period of one hour.

No. of drinks	Approximate effects
1	Feeling of relaxation and an enhanced sense of well being.
2	Feeling of well being and garrulousness.
3	Impairment of judgement and foresight. Decision making capabilities get affected.
4	Lack of motor coordination.
5	Drunkenness becomes obvious. Evident deterioration in physical and social control and competence.
7	Staggering and double vision. If this level is rapidly reached, vomiting can occur.
15	Loss of consciousness; but still the drinker can be aroused.
22-25	Breathing stops and death ensues.

Long-term effects

When alcohol is repeatedly taken in large doses over a long period of time, it proves disastrous, impairing both the length and quality of life.

An excessive intake of alcohol over a long period of time leads to severe physical damages like gastritis, ulcers, cardiomyopathy, polyneuritis, cirrhosis, pancreatitis, etc. This is because the important organs of the body like the heart, liver and brain are affected.

As a person continues to drink excessively, his tolerance for alcohol increases. That is, he is required to take more and more of it, to experience the same effect.

Prolonged and regular intake of alcohol in large doses can create tissue resistance. The body's nerve centres in try to compensate for the depressant effect of the drug in an attempt to help the body function in a balanced manner. The more they compensate, the more alcohol is required to obtain the same degree of effect. However, such tissue tolerance is developed only after prolonged and regular drinking in more than normal amounts. The moderate drinker doses not develop this tolerance to any significant degree.

Over a long period of time, the consistently heavy drinker becomes physically and psychologically dependent on alcohol.

Physical dependence occurs when body tissues have adapted themselves to alcohol and require its presence in the system in order to function normally. The body becomes so accustomed to the presence of alcohol, that as soon as its intake is abruptly stopped, withdrawal symptoms appear. These symptoms range from sleep disturbances, mild tremors, hallucinations, and convulsions, to delirium tremens and death.

An excessive use of alcohol over a lengthy period of time leads to psychological dependence.

Psychological dependence is present when alcohol becomes so central to a person's thoughts, feelings and actions (morbid preoccupation) that it is almost impossible for him to stop using it.

This form of dependence refers to a craving for the psychological effects. For those who have developed psychological dependence, even a temporary non-availability of alcohol tends to produce anxiety and feelings of panic.

To sum up,

- ★ Ethyl alcohol is a product of fermentation and distillation.
- ★ It is a drug and has no nutritive value.
- ★ It is a depressant of the central nervous system.
- ★ It is a dependency-producing, highly addictive drug.

Value additions place

— Additional information

Interaction of alcohol with other drugs

In the past several decades, hundreds of new drugs have been produced and introduced to the public. Many of these drugs are obtained only through medical prescription. Others are freely available in drug stores, super markets, etc. Some of these drugs, when combined deliberately or accidentally with alcohol, produce harmful effects.

The following table gives an idea of the possible effects:

Drugs	Possible effects with alcohol
1. Antihistamines (for cold/fever)	Increased sedation and drowsiness.
2. Anticoagulants (for problems associated with blood clotting)	Complication of blood clotting factors.
3. Anti Diabetics (for high blood sugar)	Facial flushing, headache, weakness, nausea, dizziness.
4. Anti Anginal Agents (for heart problems)/Anti Hypertensive Agents (for high blood pressure)	Sudden drop in blood pressure when a person stands up — dizziness, fainting, loss of consciousness.
5. Antidepressants (mood elevating drugs)	Increased sedation.
6. Analgesics (Painkillers)	Increased central nervous system depression, respiratory arrest.
7. Sedatives (for sleep problems)	Increased central nervous system depression, respiratory arrest, death.
8. Muscle Relaxants and Mild Tranquilizers	Increased central nervous system depression, respiratory arrest, death.
9. Antipsychotic Tranquilizers (for mentally ill patients)	Increased central nervous system depression.
10. Amphetamines (so called 'uppers')	A false sense of sobriety when the person is actually drunk.

— Additional information

Types of alcoholic beverages

Wines are made from a variety of fruits such as peaches, plums and apricots, but the most common wines are produced from grapes. The soil in which the grapes are grown and the weather conditions in the growing season determine the quality and taste of the grapes. When ripe, the grapes are crushed and fermented in large vats.

Beer is also made by the process of fermentation. A liquid mix, called wort, is prepared by combining yeast and malted cereal, such as corn, rye, wheat or barley. Fermentation of this liquid mix produces alcohol and carbon dioxide. The process of fermentation is stopped before the yeast completes its work. This is to limit the alcohol content of the beverage. The beverage, now called beer contains 6 — 8% of alcohol.

Toddy is obtained from the flowers of the coconut or palm tree. A white liquid with a sweetish taste oozes out of these flowers. This liquid is collected and allowed to ferment. At times, yeast is added to hasten the process. The fermented juice has an alcohol content of approximately 5 — 10%. When consumed fresh, this juice has no intoxicating effect.

Whisky is made by distilling the fermented juice of cereal grains such as corn, rye and barley. Scotch whisky is made in Scotland, mainly from fermented barley and it is coloured with caramel.

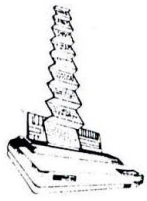
Gin, also a distilled beverage, is a combination of alcohol, water, and various flavours. Gin does not improve with age; so it is not stored in wooden casks.

Rum is a distilled beverage made from fermented molasses or sugarcane juice and is aged for atleast three years. Caramel is sometimes used for colouring.

Brandy is distilled from fermented fruit juices. Brandy is usually aged in oak casks. The colour of brandy comes either from the casks or from caramel that is added.

Arrack is a distilled beverage, obtained from paddy or wheat. Jaggery or sugar is added to either of these two cereals and boiled with water. At times sugarcane is added. This is allowed to ferment, after which it is distilled. This alcoholic beverage contains about 50 — 60% of alcohol.

Liqueurs are made by adding sugar and flavouring such as fruits, herbs, or flowers to brandy or to a combination of alcohol and water. Most liqueurs contain 20 — 65% of alcohol. They are usually drunk in small quantities after dinner.



— Additional information

Methyl alcohol

Methanol, otherwise called methyl alcohol or wood alcohol is produced through a process of chemical synthesis. It is used in paint removers, cleaning solvents, anti-freeze solutions, and liquid fuels. It is used chiefly as an industrial solvent.

Its absorption and distribution are similar to that of Ethyl Alcohol, but the rate of metabolism is very slow. The pharmacological actions initially resemble those of Ethyl Alcohol due to central nervous system depression. Then it is oxidized to formaldehyde and subsequently to formic acid and hence is more toxic. Poisoning can occur with ingestion of small quantities (15 ml).

Initial complications of toxicity include headache, vertigo, nausea, severe abdominal pain, and motor restlessness. Coma and blindness occur rapidly, and they are followed by shallow respiration (gasping) and death.

Many cases of sudden blindness and death reported after consumption of illicit liquor are due to the presence of methyl alcohol in the beverage consumed.

— Quiz

Tick the correct answer

(Answers can be checked on page 44)

	True/False
1. Alcohol is a drug	☐ ☐
2. Alcohol is digested like any other food.	True/False ☐ ☐
3. Alcohol tends to pep up a person, because it is a stimulant.	True/False ☐ ☐
4. Everyone's body reacts the same way to the same amount of alcohol.	True/False ☐ ☐
5. Alcoholic beverages are fattening.	True/False ☐ ☐
6. All alcoholic beverages are equally strong in alcohol content.	True/False ☐ ☐
7. Alcohol taken 'neat', will affect a person faster than if it is mixed with water.	True/False ☐ ☐
8. A person can sober up quickly by drinking black coffee, or having a cold shower.	True/False ☐ ☐
9. Drunkenness and alcoholism are one and the same.	True/False ☐ ☐

— Answers

1. Alcohol is a drug.

   True Alcohol is a drug. It affects the nervous system when it reaches the brain.

2. Alcohol is digested like any other food.

   False Alcohol does not need any digestion. As soon as it is consumed, it is immediately absorbed into the bloodstream through the walls of the stomach and small intestines. The blood carries it to all organs of the body.

3. Alcohol tends to pep up a person, because it is a stimulant.

   False Alcohol is only a depressant. Alcohol's first action is to depress that part of the brain which controls inhibitions. Since the person becomes less inhibited, he immediately feels more relaxed. But his nervous system is being depressed, not stimulated. Consumption of large quantities results in impairment of thought, judgement, coordination etc.

4. Everyone's body reacts the same way to the same amount of alcohol.

   False Reactions to alcohol vary tremendously. The same amount of alcohol produces different reactions in different people. This is because reactions depend on many complex physical and psychological factors.

5. Alcoholic beverages are fattening.

   True Alcohol is higher in calories than sugars and starch. The 'empty calories' in alcohol contribute to overweight. However, if alcohol is used as a substitute for a balanced diet, the person may suffer from malnourishment.

6. All alcoholic beverages are equally strong in alcohol content.

   False Alcoholic beverages are prepared by two different processes — fermentation and distillation. Distillation produces beverages containing higher concentration of alcohol.

7. Alcohol taken 'neat', will affect a person faster than if it is mixed with water.

   True Liquor taken 'neat', reaches the brain faster because it is absorbed into the bloodstream faster than when it is diluted.

8. A person can sober up quickly by drinking black coffee, or having a cold shower.

   False Nothing can speed up the sobering process because the liver oxidises alcohol only at a steady rate. One has to wait for his liver to burn up the alcohol.

9. Drunkenness and alcoholism are one and the same.

   False Drunkenness is a temporary loss of control over one's reactions and behaviour. Even a social drinker may get drunk. Alcoholism is a serious illness which requires treatment.

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6

MEDICAL COMPLICATIONS RELATED TO THE USE OF ALCOHOL

Alcoholism, *per se*, is a disease that leads to physical, emotional, psychological and social problems. It is a progressive and permanent disease. Apart from this, an excessive use of alcohol affects the functioning of various systems in the body and leads to several complications. This chapter focusses on the impact of alcohol on the different systems of the body and the consequent damages.

Alcohol and the gastro-intestinal tract

Esophagus

It is clear that alcohol damages the esophagus by direct chemical irritation to its mucosa (interior lining). It interferes with normal motor functions, thereby causing an upward movement of the stomach acid into the esophagus which erodes the tissue. The major complication in this process is haemorrhage, which is either preceded or accompanied by local pain and difficulty in swallowing. Massive, and fatal upper gastro-intestinal bleeding is also caused by the spontaneous rupture of dilated veins along the esophagus — (the dilation is a result of cirrhosis of the liver).

Stomach

Alcohol also causes acute gastric damage accompanied by bleeding. Alcohol has been widely associated with a variety of inflammatory and bleeding lesions of the stomach. The degree of the damage it causes to the lining of the stomach is related to the concentration of alcohol. Damage to the cells rapidly occurs after alcohol ingestion. The mucosal barrier gets damaged and leads to the gastric juice damaging the epithelial cells.

Alcohol damages the gastric mucosa and is believed to cause both acute and chronic gastritis. While the effects of alcohol on the stomach tissue are well known, the actual mechanism of damage has not been clearly established. However, excessive use of alcohol is known to be one of the causative factors of peptic ulcer. Symptoms such as nausea, vomiting, bleeding and epigastric pain may occur.

Small intestine

Digestive disturbances in the small intestine are common in alcoholics. Excessive administration of alcohol leads to changes in intestinal motility. In the upper part of the intestine, impeding peristaltic waves are decreased by alcohol and propulsive waves are unchanged, resulting in an increased rate of propulsion through the small intestine. This contribates to the diarrhoea frequently experienced by binge-drinking alcoholics. Together, these effects can lead to a generalised irritation of the mucous membrane in the intestine. Irritation, rather than being found throughout the gastro-intestinal system, can be localised to particular portions. Bleeding may occur at any of the irritated sites and this will present a very serious medical problem.

Intestinal malabsorption can also result from alcohol ingestion, but the degree is determined by the nature of alcohol consumed, the amount of intake and period of alcohol use. Calcium malabsorption may result from the direct effects of alcohol on the duodenum. The thiamine deficiency common in alcoholics, is partly the result of malabsorption. It is also produced by inadequate diet, decreased conversion of thiamine to its bio-chemically active form, and impairment of thiamine storage in the liver. Chronic alcohol consumption is said to lead to a decrease in absorption of iron and vitamin B_{12}, while excessive drinking inhibits the absorption of amino acids.

Depending on the level of alcohol ingested, it can also damage cells and derange cellular metabolism in the small intestine. Enzyme systems involved in carbohydrate metabolism are impaired, and activity of enzymes involved in the uptake and metabolism of lipids is increased. Enzymes involved in cholesterol synthesis are also affected.

Pancreas

Alcoholism is associated with a significant increase in the incidence of pancreatitis — a chronic inflammation of the pancreas. Most researchers believe that the disease causing mechanism is the alcohol-induced increase in protein concentration in the pancreatic juice, which is found to precipitate and form obstructive plugs in the ducts of the organ. While acute alcohol ingestion does not appear to be associated with pancreatitis, it can interfere with the pancreatic secretion of digestive enzymes that might account for some of the abnormalities in intestinal absorption associated with alcoholism.

Acute pancreatitis produces severe abdominal pain, fever, and the patient may go into a shock. This pain is steady, localised in the epigastrium and radiates to the back as it progresses. Vomiting occurs and abdominal tenderness is noticeable. Laboratory tests show amylase being considerably raised, with increased blood glucose level and increased white blood cell counts. Ultrasound or CT scan shows an enlarged pancreas. Recovery is possible with proper treatment. A very marginal percentage of patients die despite treatment.

With chronic pancreatitis, there are recurrent attacks of pain and malabsorption of food. Even with treatment, the course cannot be modified; only predisposing causes can be eliminated.

Alcohol and the liver

The liver is the largest and metabolically the most complex organ in the body. It is functionally involved in circulation, excretion, immunology, metabolism and detoxification, all of which are affected due to the presence of alcohol in the body. This organ is the first to receive digested products and other substances absorbed from the gastro-intestinal tract. It also receives substances from general circulation through the hepatic artery. Although it is the primary site for the detoxification of alcohol, the liver can be damaged by alcohol and its metabolic products.

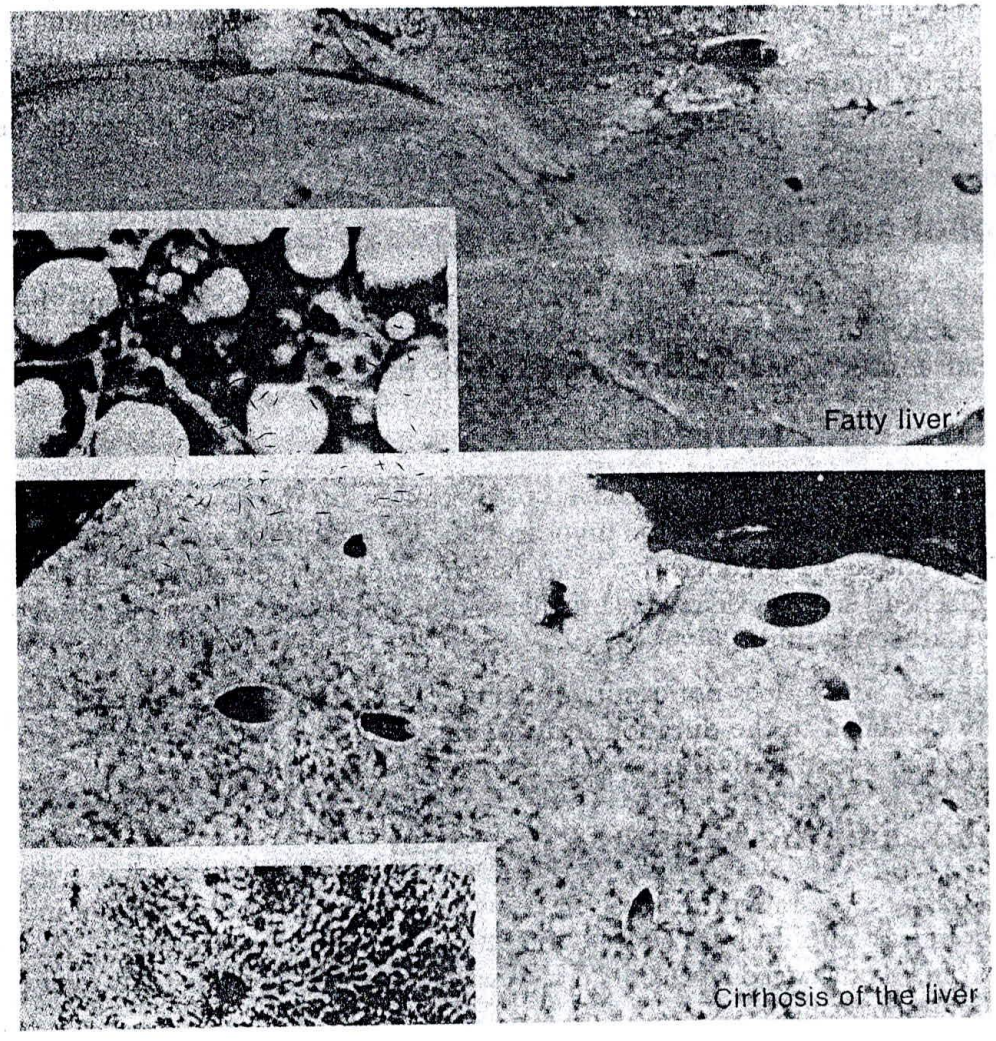
Alcohol has a number of metabolic effects on the liver. It inhibits the conversion of amino acids to glucose, a major energy producing fuel in the body. When the liver's store of glucose is low (as it often happens in the case of poorly nourished alcoholics), it results in hypoglycemia. This is similar to the condition of reduced blood sugar seen in diabetics, who have taken too much insulin. Alcohol causes three major pathological problems in the liver — **fatty liver**, **alcoholic hepatitis** and **cirrhosis**.

Alcohol stimulates hepatic synthesis of certain other proteins, including lipoproteins, which transport fat in the blood. This results in elevated blood triglyceride (fat) levels (frequently seen after alcohol ingestion). The alteration in fat metabolism results in a gradual accumulation of fat in the liver, and this in turn causes a **fatty liver**. This condition leads to liver failure and death particularly in younger people. The patient with a fatty liver may be asymptomatic or may have vague gastro-intestinal symptoms. The liver is enlarged and non-tender. Treatment is possible and the patient recovers within six weeks.

Alcoholic Hepatitis is a very serious condition which may lead to hepatic failure or cirrhosis. This often follows severe or prolonged bouts of drinking. This problem may persist even when patients give up alcohol. The most important problem experienced is jaundice. Other symptoms of alcoholic hepatitis include weakness, fatigue, loss of appetite, nausea and vomiting, low grade fever and loss of weight. Some of the changes associated with alcoholic hepatitis are reversible, if only the person totally stops drinking.

On the other hand, if he continues to drink excessively, it will result in **Alcoholic Cirrhosis**. Cirrhosis can also occur without prior occurrence of alcoholic hepatitis. The word, 'cirrhosis' means 'scarring'. In a cirrhotic liver, there is a widespread destruction of the liver cells. These cells are replaced by fibrous tissue scars. This condition is irreversible and is associated with metabolic and physiological abnormalities. The liver is unable to perform its function. Hepatic coma can occur as a result of this.

Although alcoholic hepatitis may be a precursor of cirrhosis, it also has been shown that alcohol by itself can produce **fibrosis**, and perhaps even cirrhosis without any antecedent stage. Individual susceptibility to the disease may be related to genetic and other factors in addition to heavy chronic alcohol consumption. Not all alcoholic individuals develop this disease.



Alcohol and the vascular system

Alcohol in moderate amounts causes dilation of blood vessels — especially blood vessels in the skin. This causes a sensation of warmth and flushing. Due to the dilation of blood vessels, a lot of body heat is lost and internal temperature also drops. If larger amounts of alcohol are consumed, the mechanisms which regulate body temperature get suppressed and the resultant temperature drop can be severe.

The most common disorder found in alcoholics is an increase in MCV (mean corpuscular volume). The red blood cells are larger than normal in size. This blood test is frequently done to diagnose alcoholism. Alcohol dependent persons become deficient in folic acid, since alcohol decreases the absorption of folic acid from the small intestine. This leads to folic acid deficiency anaemia.

Chronic alcohol ingestion decreases white blood cell production, and this leads to a number of infections since the white blood corpuscles are an important part of our body defense system. Chronic alcohol intake also decreases platelet function in the body by interfering with the ability of platelets to stick together. Platelets control the blood clotting mechanism, and the adverse effect of alcohol makes the person bleed profusely.

Alcohol and the heart

Alcohol and its metabolic product acetaldehyde, have specific effects on the heart muscle which can lead to problems. Alcohol consumption coupled with poor nutrition can lead to other conditions such as alcoholic beri beri.

Alcoholic cardiomyopathy

Alcoholic cardiomyopathy is believed to be caused by the toxic effects of alcohol or its metabolic products on the myocardium. Its symptoms are chronic shortness of breath and signs of congestive heart failure. It causes enlargement of the heart, abnormal heart signs, oedema, enlargement of the spleen or the liver and disturbances in the cardiac rhythm.

The disease, which does not occur suddenly, often exists in a subclinical form. Its severity is related to the duration of drinking by the patient, and the prospect of recovery is good in individuals who give up alcohol totally.

Alcohol and the respiratory system

Alcohol affects the rate of respiration. Low to moderate doses of alcohol increases the respiratory rate. In larger doses, the rate of respiration is decreased. The lungs are not directly damaged by alcohol. However, they are susceptible to its toxic effects in an indirect fashion.

Alcohol and the nervous system

Brain nerve cells generate and conduct electricity, transmitting information to the adjacent nerve cell by the release of specific chemicals called neurotransmitters. The receiving cell provides feedback to the transmitting cell regarding the message sent. Each cell can receive and integrate information from many others. This is a function which alcohol can, and does alter.

Peripheral nerve damage

Nutritional neuropathy is a most common of all the nutritional disorders of the nervous system. It is characterised by progressive weakness and muscle wasting of different degrees — more in the legs, arms and the distal muscles than in the proximal ones. Patients complain of coldness, ache, numbness, tenderness in the calf muscles and prickly sensation in the feet and fingers. Muscles become flabby, and the skin, dry, red and shiny. There is excessive perspiration on hands and feet. A shooting pain is also felt.

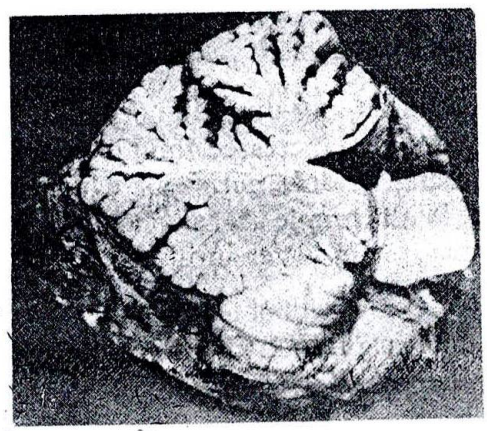
Wernicke-Korsakoff syndrome

This particular type of brain disease, its name and associated impairments are determined by the portion of the brain that is affected. Wernicke's syndrome and Korsakoff's psychosis are two such syndromes closely associated with alcoholism. Both are associated with the nutritional depletion of thiamine.

Clinically, a person with **Wernicke's syndrome** is apt to be confused, apprehensive and delirious. There is a characteristic dysfunction of the eyes (Nystagmus) — paralysis of the eye muscles that control eye movements. Nystagmus is rapid involuntary movement of the eye balls either in a horizontal or vertical direction. Nystagmus is often one of the first symptoms to occur. The patients complain of double vision and their gait becomes unsteady. Difficulty in walking is due to the peripheral and/or cerebellar nerve damage. When first seen, the patient may display signs and symptoms of alcohol withdrawal — delirium, tremulousness, confusion, hallucinosis, altered sense of perception etc. He is apathetic, listless, and disoriented.

Korsakoff's psychosis is characterised by distorted memory function. Because of the severe brain damage, the patient cannot process or store information. In order to fill these memory gaps, he makes up stories. The ability to learn is severely impaired. He will require long-term medical attention.

Alcoholic cerebellar degeneration is a complication of chronic alcohol abuse. In such cases, the patient gradually develops a slow, broad based gait as if he were about to fall down. There may not be any cognitive or mental dysfunction.



Alcoholic dementia

This occurs when a person is going through withdrawal and it is characterised by disturbances of memory and thought content. There is impairment of social and occupational functioning. Evidence of brain disorders remains due to the actual loss of cells from the cortex — the thinking portion of the brain. It is not yet known whether dementia associated with alcoholism is a primary effect of alcohol, or its metabolites on the brain, or the indirect consequences of malnutrition. Frequent head injury and liver diseases that occur with chronic alcoholism may also be a causative factor of dementia.

Neuropsychological impairment

Mental deterioration is not seen until very late in the course of alcoholism. The IQ of most alcoholics remains relatively intact and normal. Nevertheless, there are other defects like decreased ability to solve problems or to perform complex motor functions. Most of these functional impairments are not readily apparent.

Alcohol and the muscles

Alcohol is known to cause damage to muscle tissue. In binge drinkers, acute muscle damages occur as a result of which they experience pain and weakness especially in the limbs. The affected muscles may later become swollen and bruised. This indicates a certain degree of muscle tissue death. The dead muscle tissue floating in the bloodstream can clog up the kidney's filtration system. If this problem is severe, it may result in death due to kidney failure.

Chronic alcohol use can also cause peripheral muscle weakness and wasting. This is due to the direct damage caused by alcohol to the muscle itself or to the nerves that control the muscles.

Alcohol and the excretory system

Diuresis

Alcohol inhibits the release of an anti-diuretic hormone, which leads to excessive urination (diuresis). This results in increased fluid loss and it occurs only when the level of blood alcohol is rising. It does not occur when the blood alcohol level is either stationary or falling. With chronic use, alcohol itself may have an anti-diuretic effect, and an alcoholic may retain water in his body.

The initial loss of water caused by alcohol leads to the loss of some important body chemicals such as potassium, magnesium and phosphorus. This can lead to serious muscle, nerve and other damages.

Gout

The metabolism of alcohol causes an increase in the amount of NADH. With excessive NADH production, the body releases lactic acid as a by-product of converting NADH back to NAD. If too much lactic acid is formed, it can cause problems by creating an acid environment in the body cells and blood. By itself, lactic acid is not toxic. However higher quantities of lactic acid act as an environmental pollutant.

Another problem with increased lactic acid in the body is that it prevents the secretion of uric acid. When there is too much of uric acid in the blood, it causes swelling and pain in the joints.

Alcohol and the reproductive system

There is a popular misconception that alcohol improves sexual functioning. There is a common misunderstanding that alcohol acts as an aphrodisiac, and apparently increases sexual functioning. This is totally wrong. Alcohol depresses that part of the brain that controls inhibitions, and therefore the person becomes less inhibited. The problem lies, however, with the fact that although the desire exists, sexual performance and capability are diminished. Not much clinical research has been done in this area; but there does seem to be a direct correlation between increasing alcohol blood levels and decreasing sexual performance. It is proved however, that male alcohol dependents suffer from sexual dysfunction.

Alcohol affects the sexual functioning of women also. This mechanism is only poorly understood; however in alcoholic women there is failure to ovulate. Fetal alcohol syndrome is a disorder found in children born of mothers who used alcohol excessively during pregnancy.

Alcohol and the skin

The skin disorders in alcoholics are a result of vitamin deficiencies, inability to fight infections; or the person may neglect to take care of cuts and bruises when they become infected.

If an excessive alcohol user has a liver disease, **spider angiomas** can be seen especially in the upper chest area. **Acne rosacea**, the red nose of alcoholics, may result from chronic dilation of blood vessels. **Rhinophyma** or 'Brandy nose' is a result of increase in nasal sweat glands which causes an increase in the size of the lower part of the nose.

Alcohol and endocrine system

Alcohol affects the endocrine system in three major ways. It alters the function of the pituitary glands — the master gland which regulates the functions of many other glands. Alcohol directly affects other glands also and interferes with their ability to respond. Interference with the endocrine system can also develop as a result of liver damage.

Alcohol and nutrition

Prolonged use of alcohol leads to a deficiency of several nutrients. Alcohol's oxidation provides heat and energy. Because alcoholics receive so many calories from their alcohol intake, they tend to neglect other food sources and ignore nutritional needs. Therefore they develop protein malnutrition and diseases caused by vitamin deficiencies (pellegra, alcoholic beri beri, xerophthalmia or night blindness, nystagmus, dermatitis, dementia, diarrhoea and ultimately death).

The levels of magnesium, calcium and zinc are greatly reduced in alcoholics due to poor dietary intake and increased urination. Magnesium deficiency syndrome results in tremors, involuntary movements of extremity, mental aberrations and convulsions. Clinical features of zinc deficiency include dermatitis, usually generalised, loss of taste and slowness in the healing of wounds.

Alcohol and cancer

Indisputably, alcohol is one cause of cancer. Drinking alcoholic beverages exposes the drinker to an increase in the risk of cancer at various sites in the body. Heavy drinking increases the risk of developing cancer of the tongue, mouth, pharynx, esophagus, larynx and liver. Alcohol has a synergistic effect with tobacco that increases the risk of cancer.

Alcohol withdrawal

Sudden stoppage of alcohol consumption produces withdrawal symptoms like tremors, convulsions, seizures, delirium tremens etc. Delirium tremens occurs only in 5% of alcoholics. The severest form of alcohol withdrawal is **delirium tremens**. It occurs within one week of the cessation of alcohol intake. There is severe autonomic hyperactivity such as tachycardia, sweating and elevated blood pressure and severe disturbance manifested by disorientation and clouding of consciousness. There are perceptual distortions, most frequently visual or tactile hallucinations and fluctuating levels of psychomotor activities ranging from hyper excitability to lethargy. Delusions and agitated behaviour are common. Fever is also present. Grand malseizures are a common occurrence in withdrawal, although they precede the onset of delirium.

The delirious patient is a danger to himself and others because of the unpredictability of behaviour. The patient may be aggressive or suicidal or may be acting on the hallucination or delusions, thinking that they are genuine dangers. Untreated delirium tremens has a mortality rate of 20%, death usually occurring as a result of intercurrent medical illness like pneumonia, renal disorders, hepatic insufficiency or heart failure. Physical illness predisposes this syndrome — a person in good health rarely develops delirium tremens during alcohol withdrawal.

Another severe condition of alcohol withdrawal is hallucinosis. The essential feature of alcoholic hallucinosis is that it is either visual or auditory, usually beginning within 48 hours after cessation of drinking and persisting even after the patient has recovered from the symptoms of alcohol withdrawal. For most people, they are unpleasant, perhaps taking the form of voices or unformed sounds. In some cases, the hallucinations last for several weeks. Alcoholic hallucinosis is differentiated from delirium tremens by the absence of a clear sensorium in delirium tremens.

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7

ADDICTION – A DISEASE

World over, there is an increasing tendency to study both alcoholism and drug addiction as 'chemical dependency'. In this manual also, the term 'addiction' has been used to refer to both addiction to alcohol and to other drugs. Nevertheless, while elaborating, we have chosen to make a differentiation between the two. Several aspects of alcoholism and drug addiction and their manifestations have been discussed separately.

Addiction to alcohol (Alcoholism)

The common man sees 'alcoholism' as a weakness of character. The moralist looks at it as a vice. Law finds the consequential acts of alcoholism as a crime. The clergyman considers it a sin.

After extensive research, in the year 1956, American Medical Association came to the conclusion that it is a DISEASE.

Before elaborating on the disease concept of alcoholism, let us clearly understand who an alcoholic is, and in what respects he is different from the social drinker.

Who is a 'social drinker'?

A social drinker is one who drinks the way his social group permits. He never oversteps their unwritten, unspoken, but clearly understood boundaries. He either drinks occasionally, or drinks regularly in moderate quantities. His intake of alcohol does not cause any problem whatsoever in his life.

Who is an 'alcoholic'?

"An alcoholic is one, whose drinking causes **continuing** problems in one or more areas of his life (family-relationship, financial position, occupation, etc)" — MARTY MANN. Inspite of these problems, he will keep on drinking. Here, '**continuing**' is the key word. This is what differentiates him from a social drinker.

An '**alcoholic**' will not be able to take note of his problems and stop drinking totally. He tries, but never succeeds on a long-term basis. He develops a physical and psychological dependence on alcohol. He will have no control over his drinking, and even if he stops drinking for a short duration, he will definitely go back to obsessive drinking.

Out of the ten people who start drinking for the pleasure associated with it, two become alcoholics. Unfortunately, the cause is still not known.

Why is alcoholism classified as a disease?

Clinically, a disease is confirmed if the following are present:

a) The aetiological agent (that which causes the disease)

b) i) How the agent comes in contact with the patient (Epidemiology)
   ii) What happens when the contact is made (Pathogenesis)

c) The lesion — the focus of damage and its consequences — (structural, biochemical, physiological and behavioural)

d) The syndrome. (A collection of **symptoms** complained by the patient and '**signs**' observable to others that regularly occur together)

In '**Alcoholism**', the

a) Aetiological agent is Ethyl Alcohol or Ethanol.

b) i) Epidemiology — a clearly seen, but complex process.
   ii) Pathogenesis — numerous effects in the body (dealt with in chapter 6 in detail)

c) The lesion — quite clear cut in the liver.

d) Syndrome — well defined and stereotyped reaction (as we are going to see in this chapter).

Now we realise that the alcoholic is a sick person — a person with a disease.

What is alcoholism?

The most widely accepted definition of alcoholism, is the one offered by Keller and Effron: "Alcoholism is a chronic illness, psychic, somatic or psychosomatic, which manifests itself as a disorder of behaviour. It is characterised by the repeated drinking of alcoholic beverages, to an extent that exceeds customary, dietary use or compliance with the social customs of the community and that interferes with the drinker's health or the social or economic functioning."

Alcohol dependence can be both physical and psychological.

Physical dependence is a state wherein the body has adapted itself to the presence of alcohol. If its use is suddenly stopped, withdrawal symptoms occur. These symptoms range from sleep disturbances, nervousness, and tremors to convulsions, hallucinations, disorientation, delirium tremens (DTs) and possibly death.

Psychological dependence exists when alcohol becomes so central to a person's thoughts, emotions and activities, that it becomes practically impossible to stop taking it. The ethos of this condition, is a compelling need or craving for alcohol.

The characteristics of alcoholism are as follows:

It is a primary disease

Initially, alcoholism was considered a symptom of some psychological disorder. Now it has been understood that alcoholism *per se* is a disease which causes mental, emotional and physical problems. These associated problems cannot be effectively dealt with, unless alcoholism is treated first.

It is a progressive disease

If it is not treated, the disease progresses from bad to worse. Sometimes there may be intermittent periods where one feels there is improvement; but over a period of time, the course of the disease will only be towards deterioration.

It will be a terminal disease, if not treated

A person drinking excessively, may die due to some medical complication like cirrhosis or pancreatitis. But on close scrutiny, it will be found that the complication itself was induced by alcohol. Thus alcohol is the real agent behind the person's death.

It is a treatable disease

The disease cannot be cured; but it can be successfully arrested, with the help of timely, appropriate and comprehensive treatment. Treatment aims at total abstinence from alcohol. Ingestion of even a very small amount of alcohol will lead the person to obsessive drinking within a few days and he will lose control. In other words, an alcoholic can never go back to social drinking, even if he has remained sober for quite a number of years. Hence alcoholism is considered a permanent disease.

There are three distinctly noticeable phases in the disease of alcoholism.

Early phase

Increased tolerance

'Physical tolerance' is the body's ability to overcome the usual effect of a drug, so that an increased dosage is needed to experience the same effect as before.

The first warning sign for many who later develop alcoholism, is a need for higher amounts of alcohol to produce 'the desired effect'.

For instance, initially he may have taken a peg or two of whisky to experience a 'warm glow' — that relaxed and pleasant feeling. Now, it takes four to five pegs for him to experience the same effect.

As tolerance for alcohol increases, the individual starts gulping his first few drinks, so that the desired effect is felt immediately.

Black-out

This is a period of temporary amnesia which occurs during the drinking days. 'Black-out' should **not** be confused with 'passing out' which means unconsciousness. During a 'black-out', the person may go through many activities, without being able to recall even a trace of them later on. The person walks, talks, even drives "apparently normally"; but has no recollection of it afterwards.

People who are not alcoholics, may also occasionally have black-outs. However, in people progressing towards alcoholism, repeated episodes of black-out occur.

> *35 year old Rakesh hails from an orthodox, religious family. He had been drinking for over ten years. His drinking, however, gradually became excessive. He always arrived home late, totally drunk.*
>
> *One day, as usual, Rakesh came home in an intoxicated state. He complained that the food was not to his liking; he shouted at his wife; aggressively got up and smashed all the pictures in the pooja room, and then fell asleep.*
>
> *Next morning, when Rakesh got up, he was surprised to see his mother and wife sulking in a corner. Nobody spoke to him.*
>
> *Rakesh asked his mother,*
>
> *"What happened? How is it that you are not busy with the usual pooja?"*
>
> *His wife got angry and went away without speaking a single word. His mother narrated what he had done the previous night.*
>
> *Rakesh was taken aback.*
>
> *He was totally shaken; for he did not remember anything — not even a trace of it.*

Preoccupation with drinking

Even when the alcoholic is not drinking, he is always preoccupied with thoughts of how, when and where he could get the next drink. While at work, he may be thinking about and waiting to get his drinks at noon, during lunch break. When going to a party, he somehow finds out if there will be alcohol. Drinking is synonymous with having a good time. If drinking is not going to be part of any activity, his response will be, "Count me out".

Avoiding any talk about alcohol

This is a result of his feelings of guilt. Formerly he had been formerly boasting about how much he could drink; but now he does not want to talk about it at all. If someone else brings up the subject, he totally diverts the topic, for fear that they will talk about his drinking. He does not want to talk about, listen to, or even read anything which has reference to drinking.

Middle phase

Loss of control

Initially, there is a loss of control over the quantity of alcohol consumed. That is, the person is not able to predict what will happen after the first drink. Intending to have one or two pegs on his way back home from the office, he enters a bar; but he is still drinking till the bar closes.

As alcoholism progresses, the patient will lose control over the time and place of drinking (comes drunk early in the morning to the office).

He now reaches a point when he literally cannot keep away from drinking, or control the amount consumed. Drinking becomes compulsive. Now he is totally powerless over alcohol. Loss of control is a clear-cut sign that alcoholism has now developed. The warning signs are gone. It may get worse; but he is not likely to get better without help.

> *Satish had been drinking alcohol for quite a number of years. His family wanted to go to Tirupati and he had agreed to take them. In all earnestness, he stopped drinking 2/3 days prior to the trip. On the appointed day of travel, Satish and his family boarded the train as planned.*
>
> *At one of the stations, Satish got down to fill his water bottle. As he was filling the bottle, he spotted an arrack shop just outside the platform. He was tempted. He knew that the train would stop there for a few minutes, and there would be time for him to have one drink. He thought, "Let me have only one drink .. nothing more!".*
>
> *He started with only one drink... wanted to have one more quick one. He had another... one more... one more... etc.*
>
> *When he came out, it was too late; the train had left the station long ago.*

Justifying his drinking

He feels guilty and depressed. He begins to rationalise. He develops an elaborate defence system of reasons and excuses to reduce his guilt feelings. He will keep on explaining as to why he drinks a little too much, and gets a little too drunk.

Grandiose behaviour

Another way by which an alcoholic avoids the truth about himself and his condition, is by exhibiting grandiose behaviour which is inconsistent with his financial and professional capabilities. For example, he buys things he does not need, gives lavish gifts and pays others' bills at the bar.

Mohan had been drinking excessively for three years. He had borrowed money from various people and his debts had mounted up.

One day, a shop-keeper came, stood outside his house and shouted:

"You have not yet paid my dues which you promised to pay last month itself. I want the money right away! I will return in the evening to collect it from you. If you fail to repay, I will drag you to the police station!"

Mohan's wife felt extremely ashamed, and was terribly annoyed. Mohan told her, "Don't worry! Today I will take a loan from my salary. We can pay him back this evening itself."

Mohan went to the office. On his way back home, he bought five packets of 'Gold Flake' cigarettes and happily distributed them to his friends. They smoked and drank together. Mohan called for a taxi, and when he came back home, he had no money left to pay the taxi driver.

Aggression

Since he believes that others are the cause for his problems, he strikes out against them with verbal abuse, sometimes even with physical abuse. Such abuses are only an expression of self-hatred directed towards someone else.

Guilt and remorse

Now he slowly becomes aware of what he had been doing to himself and to others. He is unable to throw it off as easily as before. He feels a deep sense of personal guilt and this guilt and remorse often lead him back to the bottle. But when the alcohol is gone, his guilt remains. These feelings now become as much a part of his alcoholism as drinking and getting drunk.

Abstaining from alcohol

He attempts to quit on his own — to give up alcohol — not for ever, but for a definite period of time. He feels this will 'prove' that he can give up drinking whenever he wants to. He may stay away from alcohol for a period of time he has set — a week, a month, or whatever — but then his compulsion for alcohol may make him either shorten the period of time he has set for himself, or he may be able to abstain for the set period; in either case, after this stretch, he will inevitably go back to obsessive drinking.

Changing the drinking pattern

After trying to abstain, he now takes another precaution. He changes his drinking pattern to show that he can start drinking again without experiencing the same old problems. He changes drinks — from whisky to beer, or shifts the place and time of drinking. But no matter how many changes he makes, if it is alcohol he is drinking, he will soon be immersed in the same problems which haunted him before.

Decaying of social relationships

As he continues to drink, he becomes aggressive. This is the time his friends start moving away. He may start establishing new friendships, where people are in tune with his drinking pattern. When he comes out of his problem of addiction, it is a painful discovery for him to realise that his 'so called friends' were nothing more than 'mere drinking friends'.

Problems on the job

Until now, his job may not have been affected. But he can no longer hide his hangover, his absenteeism and low quality of work. Everyone becomes aware that he is drinking too much. He is now being watched. He receives memos, suspension orders. He may even lose his job.

Family problems

Now he is unable to keep the family together in peace. The major problems begin to weigh heavily on his wife and children. They suffer due to unmanageable problems.

Morning drink

Physical dependence is very apparent. The morning drink takes care of the hangover, the jitters, the guilt, the remorse and the depression.

He needs it to start the day. This initiates the cycle of continuous drinking and speeds up the progression of alcoholism.

Seeks help

Problems with the family and on the job mount up. These motivate him to seek help. But even now, he will not seek help for his alcoholism. He wants help only to put the rest of his life back in order.

Chronic phase

Now he is getting close to the bottom. Other alcoholic complications like gastritis, liver dysfunction and polyneuritis occur.

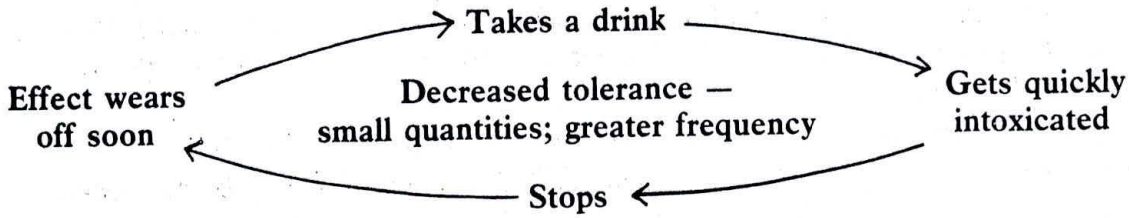
He has a total breakdown in his relationship with the family. There is considerable confusion and mental deterioration.

Binge drinking

Now the alcoholic has absolutely lost control and goes on drinking continuously for several days, and this is referred to as a binge. He is utterly helpless. There is a total disregard for the family, job, everything. At the end of such a 'binge', he is left in a shaking, frightened, guilt-ridden condition. He promises never to drink again. But it happens over and over and again.

Decreased tolerance

Initially, the alcoholic needed more and more alcohol to experience the 'desired effects'; or in other words he had 'increased tolerance'. Due to severe physical deterioration, the alcoholic now gets 'drunk' even with very small quantities of alcohol. Drinking smaller amounts results in higher degree of blood alcohol concentration than in the past.



Ethical breakdown

The alcoholic is so dependent on alcohol that he will lie, borrow or even steal in order to maintain his supply of alcohol.

John, 42 years — married with two children. He had been drinking excessively for a few years, as a result of which he was facing a financial crisis.

He was totally broke.

He had no money to pay his children's school fees.
Many of his bills remained unpaid.

In spite of his financial problems, he could not stop drinking. He desperately needed money to buy alcohol.

He went to the church one day. The plate for collecting mass-offering came round. Without any hesitation, he put a fifty paise coin in the plate, and took away a five rupee note.

He immediately went to the arrack shop and spent this money on alcohol.

Paranoia

At this stage, the alcoholic is suspicious that everyone is watching him, talking about him or even plotting against him. He is a victim of circumstances over which he has no control.

He becomes jealous of everyone — of friends, of neighbours, even of his own family. With a male alcoholic, there is a loss of sexual desire/functioning at this stage. This results in him becoming suspicious of his wife having affairs with other men. This is an extension of his inability to perform as a marital partner.

Indefinable fear

He is frightened by nameless fears. Now he is afraid even to cross a road, enter a dark room, etc — frightened of all kinds of things which are in no way related to reality.

Hallucinosis

Auditory (imagining voices speaking), visual (seeing non-existent things) and tactile (feeling as though something is moving on the skin) hallucinations are experienced.

Bhajan Singh had been drinking for nearly 30 years. His family and friends had been requesting him to either stop or reduce his alcohol consumption. He did neither.

One night, Bhajan Singh was behaving in a very strange manner.

He said that he saw Rajiv and Sonia Gandhi entering his house. He ran, woke up his wife and asked her to prepare tea for the eminent visitors.

He could hear several people shouting, "Long live Sonia Gandhi! Long Live Rajiv Gandhi!" To him, these voices were clear and distinct. He started repeating the slogans and asked his wife also to join in.

His wife got terribly scared. She felt he was mad. She did not know that he was experiencing visual and auditory hallucinations.

Lack of motor co-ordination

At this point, he loses most of his motor co-ordination. He is unable to tie his shoes, or button his shirt, until he 'steadies' himself with a few drinks. His legs and arms do not respond automatically. He experiences shakes and tremors. This is not the first time he is experiencing tremors. But formerly he could control them by taking 'more alcohol'. Now the 'shakes' are more pronounced, and alcohol does not help in 'quietening them'.

Turning to God

He becomes desperate. He is unable to face the reality of his situation and turns to God for help. Even now, he does not ask God to remove his desire for alcohol. He pleads with God to help him to maintain a supply so that he can manage his drinking. His entire being is nearly destroyed by addiction at this stage.

Finally, the inevitable vicious circle begins. He gets sick, drinks to feel better and becomes ill again. This continues endlessly. He drinks just for the sake of drinking; he drinks only to stay alive.

When he reaches this stage, two things may happen to him. He continues to take alcohol and becomes mentally ill.

or

He continues drinking and dies a premature, painful death.

The only solution to this problem is to stop drinking totally for life.

Addiction to drugs (Drug addiction)

Just like 'Alcoholism', dependency on any other drug is also a disease — a primary, progressive, yet treatable disease. Here also abstinence is the one and only solution to the problem.

The disease is progressive and goes through distinctly defined stages as in the case of alcoholism.

Early stage

- Quantity of drug intake increases and doses are taken more frequently. Increasingly, more time is spent using the drugs and in being in the intoxicated state.
- Alters situations to facilitate increased use of drugs — reduces time and money spent on other non-drug behaviour. e.g., Cuts down money spent in the cafeteria to ensure sufficient money for the drug.
- Thoughts and conversation centre often around drugs. Thinks about when he can use the drug, from whom he can get or how he is going to pay a lower price.
- Rationalises his use of drug. May tell himself that drugs are not dangerous to use and "drug warnings" are not based on facts.

Middle stage

- Tolerance for the drug increases dramatically.
- Addiction develops — he needs the drug to ensure a sense of well being and later on, to avoid withdrawal symptoms.
- Is unable to limit drug use. Frequently, loses control over the occasions when he uses drugs.
  e.g. Previously he might have desisted from using the drug during his monthly tests but is now unable to do so.
- Resolves often to stop drug use; but his repeated efforts only fail. Substitute drugs are tried.
  e.g. Heroin addicts may try alcohol or other barbiturates.
- Maintains hidden supply of the drugs because the very thought about its absence is threatening.
  e.g. The nurse addicted to pethidine may start buying them, in addition to pilfering from the hospital supply.
- Begins to have problems at school, college, and place of work.
  e.g. Decline in performance, poor attendance etc.

— Uses drugs to handle unpleasant emotional states and sometimes uses them even when he anticipates problems.
e.g. Feeling of embarrassment about test results; anger and irritation when parents question about his frequent absence from home.

— Family relationship becomes strained — neglects responsibilities; is not dependable.

— Personality shifts are observable — person is more irritable and withdrawn.

— Alienation from friends who were close to him prior to drug use. Interest in extra curricular/leisure activities decline considerably.

— Neglect of personal hygiene — poor grooming and poor eating habits.

— Feelings of anxiety, guilt or shame may strengthen.

Advanced stage

— Drug use turns continuous.

— Loss of control over the drug is complete. Experiences less and less pleasure from the drug; but continues using it to avoid withdrawal symptoms.
e.g. Heroin addicts often complain that the intensity of euphoria is not the same as before.

— Cheaper drugs are used when the drug of choice cannot be obtained.
e.g. Heroin addicts may use other depressant drugs.

— The individual becomes increasingly dependent on other people to carry on the pretense of living. He often eats only because he is pressurised to.

— Social relationships are almost non-existent and companionship is limited almost exclusively to drug addicts.

— Person may leave home and start living alone.

— Many face premature death due to poor health condition.

Elements of the syndrome

The drug dependent's life-style is altered in many ways. The shifts can be studied from different angles.

Behavioural changes

As the disease develops, behaviour becomes more and more drug related. Life seems to revolve around drugs.

— Drug usage becomes more heavy and more frequent. From weekend use of ganja, he proceeds to everyday use, and finally to a state of continuous intoxication.

- Initially attempts to reduce drug usage but succeeds only for a very short while. Slowly loss of control becomes more and more evident.
- Seeks occasions to use drugs and "friends" who use them regularly. The individual becomes more skilled at obtaining, using and covering up his use of drugs. When compulsive usage develops, daily activities revolve only around drugs. He seems to live only for the sake of drugs.
- Poor grooming, total unconcern for personal appearance and utter disregard for the opinions of others become pronounced.

Psychological changes

- Initially, uses drugs to feel better — more confident, get relief from anxiety, etc. Slowly reaches a stage where he feels normal only with drugs. In the chronic stage, he does not enjoy usage but is unable to stop.
- Emotional reactions — Mood swings related to drug use are evident. Gradually personality changes, increased emotional liability can be noted. User feels increasingly resentful, guilty, inadequate, and inferior. In the advanced stage, behaviour is erratic, becomes increasingly apathetic and feels deserted and lonely.
- Cognitive process — In the initial phase, user is mentally obsessed with thoughts about drug taking. With continued use, increased deterioration of self image, self deception about drug use and its effects develop. Confusion, lack of objective perception of himself and the world around him become more prominent.
- Judgement and insight — Initially, when off drugs he is able to express concern about drug use and is able to get out of problems created by it. Problem solving becomes increasingly difficult; very poor insight and extremely poor judgement are evident in the late phase.

Social changes:

- Interpersonal relationships — As the disease progresses his choice of friends shifts from abstainers to heavy users. His interpersonal relationships weaken considerably in the second stage, as he repeatedly breaks promises, utters lies, takes advantage of others' sympathy and uses them to buy drugs. In the late phase, he becomes increasingly manipulative.
- Family relationships — Even in the initial stage user is argumentative, withdrawn, and spends very little time at home. As the disease develops, lying, stealing and violence weaken his relationship with family members. Most drug dependents, in the chronic stage, are fully alienated from their family and often start living alone.
- Social activities — Loses interest in non-drug activities even in the initial stage. As the disease grows, he becomes more involved in the world of drugs and even his 'short lived friendships' are made only with drug dependents.

— Educational/occupational performance — Decreasing grades, poor attendance can be noted in the initial stage. As the disease progresses, more problems crop up and he may be suspended or may drop out voluntarily.

— Management of finances — Initially, spends money intended for other activities on drugs by curtailing his interests. As the need for the drug increases, he spends all the money that he gets on drugs. In the later phase, he becomes involved in illegal activities and may also be in debt.

The drug dependent person may exhibit many or most of the signs and symptoms listed above in a variety of combinations. The problems or damages which may follow also occur in diverse combinations. The degree to which the dependency is developed also varies widely. It is the responsibility of the consellor not to simply label the patient as an addict but rather to specify what signs and symptoms support such a diagnosis.

Value additions place

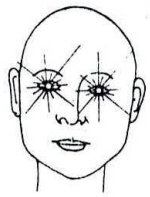
— Additional information

Jellinek's classification

The question, **'Is Alcoholism a Disease?'** has been analysed in detail by E M. Jellinek, a former consultant on alcoholism to the World Health Organisation. He concludes that there are several types of 'alcoholism'. Common to all types are two features — drinking and the damages it causes. He names five common sub-species of the 'genus' alcoholism. They are listed in the table below:

Jellinek's classification

Type		Characteristics
Alpha	α	Purely psychological dependence; the individual drinks only to free himself from pain.
Beta	β	No physical/psychological dependence; heavy drinking combined with poor nutritional habits lead to severe physical damages.
Gama	γ	"Loss of control" — inability to abstain from alcohol for long periods of time.
Delta	δ	No loss of control, but inability to abstain. Drinks intermittently everyday but does not necessarily get drunk.
Epsilon	ε	Periodic uncontrollable drinking (BINGE).



— Perceptive findings

Three distinct stages of alcoholism

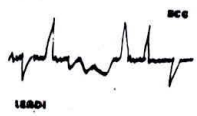
Warning signs	As felt by the patient	As perceived by others
Early stage		
Increased Tolerance	Increased amounts of alcohol are required to experience 'the same kick'.	Remains 'steady' even after many drinks.
Blackout	People say "I did this; said that! Can it be true? Am I forgetting totally?"	Has become a liar. Refuses to believe others when they tell him how he behaved.
Preoccupation	"I want to drink;... Yes, right away!"	Gives lame excuses for going out; always returns drunk.
Avoiding references to alcohol	"They have again started talking about alcohol. They are sure to pounce on me finally. I have to stop this conversation!"	Even at the mention of alcohol, he flares up, gets angry, walks away, or changes the topic.
Relief drinking	"Drinking helps me to overcome negative emotions like stress, anger or anxiety."	Drinks at the slightest provocation (criticism, conflict or stress).
Middle stage		
Loss of control	"I'm not able to stop with one or two drinks; I am unable to exercise control over the time or occasion of drinking".	Drinks continuously — anywhere; anytime of the day.
Denial	"I do drink; but it does not cause any problems. Everybody is exaggerating".	Finds reasons, excuses for his behaviour.

Grandiosity	"I have a lot to give others. Let me give away something to others also."	Talks 'big' about himself; spends far beyond his means.
Aggression	"Others are too unreasonable. They make me angry."	Physical, verbal abuse; breaks articles.
Abstaining for short periods	'If I want to stop, I can do it; I have proved it before."	He can give up drinking if only he wants to. He did it when he went on a pilgrimage. He only has to make up his mind.
Solitary drinking	"I prefer to drink alone."	Drinks at home all alone.

Chronic stage

Binge drinking	Is not able to avoid continuous drinking.	Drinks day in and day out — from morning to evening.
Decreased tolerance	Unable to drink as much as before.	Even with a very small quantity he gets intoxicated.
Ethical breakdown	"I must have alcohol right now. I do not care how I get it."	Steals money; tells lies about money matters; has lots of debts.
Feeling of fear	Indefinable fear.	Refuses to open the door when someone rings the bell; hides himself when people come to his house.
Paranoia	"Everybody is after me. They are going to harm or kill me! My wife is also having affairs with other men."	Suspects his wife; believes she is having an affair with someone else.
Hallucinosis	Hears voices, sees visions, feels something is crawling on his skin.	Afraid he is getting crazy.
Lack of motor coordination	Unable to control body movements.	Is not able to button his shirt, tie his shoe laces, or hold a glass.

Note:
These **perceptive findings**, can also be effectively used as a **diagnostic tool** to gather valuable information about the patient.



— Diagnostic tool

Diagnostic criteria

All over the world, two main systems are followed for diagnosis in psychiatry. One is the International Classification of Diseases 9th Revision (ICD-9) published by the World Health Organisation (WHO). The second is the Diagnostic and Statistical Manual, 3rd edition Revised (DSM-IIIR) published by the American Psychiatric Association, USA. The diagnostic criteria as stated by these two Manuals are given below:

ICD – 9

Alcohol dependence syndrome

A state, psychic and usually also physical resulting from taking alcohol, characterised by behavioural and other responses that always include a compulsion to take alcohol on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence; tolerance may or may not be present. A person may be dependent on alcohol and other drugs; if so also make the appropriate coding. If dependence is associated with alcoholic psychosis or with physical complications, both should be coded.

Drug dependence

A state, psychic and sometimes also physical, resulting from taking a drug, characterised by behavioural and other responses that always include a compulsion to take a drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on one or more than one drug.

The various sub-categories listed are:

— Morphine type
— Barbiturate type
— Cocaine
— Cannabis
— Amphetamine type and other psychostimulants

— Hallucinogens
— Others
— Combinations of morphine type drug with any other
— Combinations excluding morphine type drug
— Unspecified

DSM III – R

This classificatory system prefers to call this group as **psychoactive substance use disorders.**

Diagnostic criteria for psychoactive substance dependence

A. At least **three** of the following:

1. Substance often taken in larger amounts or over a longer period than the person intended.
2. Persistent desire or one or more unsuccessful efforts to cut down or control substance use.
3. A great deal of time spent on activities necessary to get the substance (e.g. theft), taking the substance (e.g. chain smoking), or recovering from its effects.
4. Frequent intoxication or withdrawal symptoms when expected to fulfil major role obligations at work, school, or home (e.g. does not go to work because of a hang-over, goes to school or work 'high', intoxicated while taking care of his or her children) or when substance use is physically hazardous (e.g. drives when intoxicated).
5. Important social, occupational or recreational activities given up or reduced because of substance use.
6. Continued substance use despite knowledge of having a persistent or recurrent social, psychological or physical problem that is caused or exacerbated by the use of the substance (e.g. keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking).
7. Marked tolerance: need for markedly increased amounts of the substance (i.e. at least 50% increase) in order to achieve intoxication or desired effect, or the markedly diminished effect with continued use of the same amount.

Note

The following items may not apply to cannabis, hallucinogens or phencyclidine (PCP).

8. Characteristic withdrawal symptoms.
9. Substance often taken to relieve or avoid withdrawal symptoms.

B. Some of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

Diagnostic criteria for severity of psychoactive substance dependence

Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupational functioning or in usual social activities or relationships with others.

Moderate: Symptoms or functional impairment between 'mild' and 'severe'.

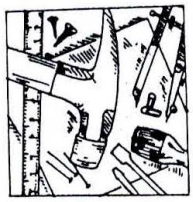
Severe: Many symptoms in excess of those required to make the diagnosis and the symptoms markedly interfere with occupational functioning with usual social activities or relationship with others.

In partial remission: During the past 6 months, some use of the substance and some symptoms of dependence.

In full remission: During the past 6 months, either no use of the substance, or use of the substance and no symptoms of dependence.

Diagnostic criteria for poly substance dependence

This category should be used when for a period of at least 6 months, the person has repeatedly used at least 3 categories of psychoactive substances (not including nicotine and caffeine), but no single psychoactive substance has predominated. During this period the criteria have been met for dependence on psychoactive substances as a group, but not for any specific substance.



— Implementation tool

Screening test

Standard psychological tests are being extensively used for evaluation of alcoholism. Many scales have been developed. Of these, the Michigan Alcoholism Screening Test (MAST) is used more often. The MAST is a relatively short screening test that asks direct questions about alcohol consumption. Validation efforts have been impressive, and objective confirmation of MAST diagnosis have been obtained from a variety of institutional and public records. A copy of the screening test, along with the scoring and interpretation key has been given here for your use.

Michigan Alcoholism Screening Test (MAST)

Instructions: Here there are 25 questions. For each question, you have to answer by ticking 'Yes' or 'No'. This is not an ability test. Please read carefully and indicate your choice as directed above.

	Yes	No
1. Do you feel you are a normal drinker?	☐	☐
2. Have you ever awakened in the morning after some drinking the night before and found that you could not remember a part of the evening before?	☐	☐
3. Does your spouse (or parents) ever worry or complain about your drinking?	☐	☐
4. Can you stop drinking without a struggle after one or two drinks?	☐	☐
5. Do you ever feel bad about your drinking?	☐	☐
6. Do friends or relatives think you are a normal drinker?	☐	☐

7. Do you ever try to limit your drinking to certain times of the day or to certain places?	☐	☐
8. Are you always able to stop drinking when you want to?	☐	☐
9. Have you ever attended a meeting of Alcoholics Anonymous (AA) ?	☐	☐
10. Have you gotten into fights when drinking?	☐	☐
11. Has drinking ever created problems with you and your spouse?	☐	☐
12. Has your spouse (or other family member) ever gone to anyone for help about your drinking?	☐	☐
13. Have you ever lost friends or girl friends/boy friends because of drinking?	☐	☐
14. Have you ever gotten into trouble at work because of drinking?	☐	☐
15. Have you ever lost a job because of drinking?	☐	☐
16. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	☐	☐
17. Do you ever drink before noon?	☐	☐
18. Have you ever been told you have liver trouble? Cirrhosis?	☐	☐
19. Have you ever had delirium tremens (DT's), severe shaking, heard voices, had seizures or seen things that were not there after heavy drinking?	☐	☐
20. Have you ever been in a hospital because of drinking?	☐	☐
21. Have you ever gone to anyone for help about your drinking?	☐	☐

22. Have you ever been a patient in a psychiatric hospital or in a psychiatric ward of a general hospital where drinking was a part of the problem? ☐ ☐

23. Have you ever been seen at a psychiatric or mental health clinic or gone to a doctor, social worker, or clergyman for help with an emotional problem in which drinking had played a part? ☐ ☐

24. Have you ever been arrested, even for a few hours, because of drunk behaviour? ☐ ☐

25. Have you ever been arrested for drunk driving or driving after drinking? ☐ ☐

8

DENIAL*

'DENIAL' is a psychological process that takes place at the unconscious level in the alcoholic. During this process, the alcoholic's mind recreates an illusion so convincingly that he believes it to be a 'reality'. He is not consciously aware that this change in thinking is taking place. People who are close to him, will definitely be able to identify the methods of denial adopted by the alcoholic.

What exactly is 'Denial'?

The individual will not report accurately the quantity, frequency or the problems associated with his excessive alcohol consumption. The adverse behavioural consequences and the problems associated with his drinking will either be minimised, explained away, rationalised or denied completely. In short, there will be a denial of reality.

For example, violent fights with the wife may be described as a minor argument, or rationalised as due to the arrogant behaviour of the wife, or simply ignored.

The wife, friend, relative, or even a counsellor may perceive this 'denial' of the alcoholic, as lying, – a method deliberately adopted by the alcoholic to escape taking responsibility for his harmful actions. As a result of this, people close to him become hostile and develop an intense hatred and dislike towards him for his dishonesty and irresponsibility.

This chapter is intended to help in clarifying the factors which produce and maintain the 'denial mechanism' of the alcoholic, so that everybody including the counsellor may respond helpfully rather than reject the alcoholic.

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* Over the years, it has been established that 'Denial' is part of the disease of addiction — be it addiction to alcohol or any other drug. The name of the particular chemical abused is not important in recognising the illness, and consequently the words 'alcohol' or 'alcoholic' used in this chapter can very well be applied to any other chemical or chemical dependency. It does not make any difference as to which chemical is being talked about.

Why do alcoholics deny their problems?

Drinking is an accepted behaviour in our society, and alcohol is projected as an essential part of 'good life'. For most people, drinking is a harmless activity normally associated with social occasions. Unfortunately, in the case of two out of the ten people who drink, alcohol use slowly deviates from a harmless to a harmful activity. Once the person starts developing problems, he is branded a 'drunkard' and a social stigma immediately gets attached to him.

In other words, we reinforce drinking, but stigmatise the victim of alcoholism. He is looked upon as an evil person who deserves to be punished, rather than as a sick person who needs understanding, support, and above all, professional help.

Normally, nobody wants to be categorised and stigmatised as an evil person, morally and mentally inferior to others, and subject himself to punishment, disapproval, rejection and social boycott. This is one of the factors which set the stage for denial.

Two diametrically opposite beliefs can never coexist for a very long period in one individual.

As a person's drinking begins to lead to problems, a conflict is created. On the one hand, alcohol has become a very important component of his life. He likes to drink because it produces a feeling of wellbeing and helps him to forget problems. On the other hand, reality is trying to reinforce awareness in him about the problems created by alcohol in his family, occupation, social life etc.

At this point, he has only two options before him — reject drinking or reject reality. He begins to reject reality because he is unable to exercise the other option however hard he tries.

As the disease of alcoholism progresses and becomes worse, giving up drinking becomes increasingly difficult. Realities of life appear more and more bitter and consequently the mechanism of denial also becomes fully reinforced.

- The moral stigma associated with alcoholism provides the ground for 'denial'.
- The tendency of family, co-workers and friends to cover up the consequences of the alcoholic's adverse behaviour provides the social environment which promotes and encourages 'denial'.
- The individual's normal tendency to avoid internal conflict encourages denial of unpleasant reality.

Early use of alcohol generally changes the individual's mood in a positive way. Most people start using mood altering chemicals in a social setting with friends, to help them 'loosen up'.

The alcoholic learns that the use of alcohol makes him feel better. To him it is a compulsion, not an option. For a few hours, it makes him forget his problems, reduces his fears and tension; removes his feelings of loneliness and gives him an impression that he is able to solve all the problems.

Gradually, there appears a difference in the emotional effect of using alcohol for the person who begins to become dependent on it.

In the initial stages of alcoholism, the alcoholic drinks much more than others; he doesn't sip drinks; he gulps fast; and conceals the amount he drinks. He drinks **more than** others; **more often** than others; and above all, it means **far more to him** than to others.

For him, drinking is no longer a matter of choice; it is no more a display of his strength. This is the first sign of his alcoholism. Repeated 'denial' by hiding the bottle and drinking alone shows how necessary alcohol has become for him to lead his life. He starts with one drink and goes on and on; he is unable to stop.

Everyone and everything which were hitherto important in his life become secondary and the alcoholic begins to reject everything which he feels may threaten his continued use of alcohol.

The reason why the alcoholic is unable to perceive what is happening to him is understandable. As this condition develops, his self-image starts deteriorating. For many reasons, he is unable to keep track of his own behaviour and he is losing contact with his emotional self. His defence systems continue to grow, so that he can survive in the face of his problems. The greater the pain he suffers, the higher and more rigid the defences become; and this whole process takes place without his conscious knowledge. Finally, he becomes a victim of his own defence mechanism.

His rational activity turns into real mental mismanagement. This serves to erect a secure wall around the increasingly negative feelings he has about himself. The end result is that he is separated from those feelings and becomes largely unaware that such destructive emotions exist within him. Not only is he unaware of his highly developed defence system, he is also unaware of the powerful feelings of self-hatred buried behind it, sealed off from conscious knowledge, but explosively active. Because of this, his judgement is progressively impaired.

In short, instead of returning to 'feeling normal' after the 'high' wears off, the person experiences negative consequences due to an excessive use of alcohol (e.g. embarrassment arising out of actions done under intoxication such as aggression, drunken driving, blackouts etc). The problem gets compounded by the fact that these defences, by locking in the negative feelings, have now created a mass of free-floating anxiety, guilt, shame, and remorse which become chronic in the course of time.

The person is no longer able to start any given drinking episode from the 'normal point', whereas before his illness he could always do so, and then proceed to 'feel good'. Now he starts from a depressed or painful emotional state and drinks to feel normal. In the final stage of alcoholism he has no option but to drink in an attempt to feel normal.

Because there is an absolute dependence on alcohol, it is impossible for him to fully realise that there is a tie between his negative feelings or behaviour and alcohol.

'Denial' or an addictive thinking pattern begins to develop to protect the alcoholic from the reality of his alcoholism. As already stated, it is a defence mechanism used to protect himself from the guilt, shame and blame which usually accompany the consequences of his continued excessive use of alcohol. As he becomes more and more dependent on alcohol, the 'denial mechanism' takes various shapes.

Let us discuss some of the most common forms of denial.

Simple denial

Initially, the alcoholic totally denies the existence of any problem associated with his use of alcohol, even though these problems are quite obvious to others.

For example, the alcoholic may admit that he takes alcohol, but denies the fact that his alcohol intake has produced any adverse consequences.

> *"Drinking produces no problems whatsoever. As a matter of fact, I feel 'good' and I am able to solve my problems better after drinking."*

Minimising

He accepts that his drinking leads to some problems; but keeps on repeating that these problems are not as much or as many as the others make it out to be. He tries to convince himself that it is much less serious than what it actually is.

> *"I drink, alright;... but it is not all that bad ... I drink only on weekends. I give enough money to my wife to run the family. I am not spending excessively on my drinks, as she complains. It certainly does not cause any financial problem as it is made to appear."*

Blaming or projecting

The alcoholic blames others for his own shortcomings. In this case, he denies responsibility for many of his alcohol-related problems and shifts the responsibility to someone else.

It is only the cause of the behaviour which is denied and not the behaviour itself.

> *"My wife does not respect me. I slog only for her and for my children. But she does not understand of my problems. She is constantly on my back. She does not bother about my feelings at all. I drink only to forget my misfortune."*

Rationalising or giving excuses

The alcoholic gives innumerable excuses, justifications, and alibis for his behaviour; but never admits that the real cause for his adverse behaviour is his excessive use of alcohol.

"My boss keeps on saying that I have not completed my assignment on time. This is because he is totally prejudiced against me and never cooperates whenever I ask for help! I drink only to calm my nerves!"

The alcoholic never accepts that alcohol is the real reason for his bad performance.

Intellectualisation or explaining away feelings

Here the person avoids facing alcohol-related problems by dealing with them on a superficially general, theoretical or intellectual level.

"I am a doctor and I know what it means to be an alcoholic. How can you ever come to the conclusion that I drink excessively, thus damaging my liver or brain? Do you really think that I am as stupid as all that?

Anyway, I will not get angry with you, because it does not do any good anyway!"

Diverting

The alcoholic changes the subject of conversation whenever any reference to alcohol use or alcohol-related problems crops up.

The alcoholic's friend says,

"You are developing severe problems due to excessive drinking. It is high time that you take care of your health, see a doctor and go for treatment."

The alcoholic does not allow his friend to even finish the sentence. He immediately interrupts and diverts saying,

"I heard you have not yet booked your ticket to Bombay. Nowadays bookings are becoming difficult. You have to book sufficiently in advance. The booking clerk is my friend and I will certainly help you in booking your ticket."

Hostility

Another form of denial which the alcoholic may use to his advantage is anger and irritability.

For instance, he may get extremely angry and aggressive whenever the topic of addiction is broached because he has learnt by his experience that his anger will make the other person avoid that topic or leave that place.

Silence

Here the addict maintains strict silence whatever be the provocation. He uses this method to withdraw from reality.

The '**Denial Mechanism**' in its various forms is always supported by people around the alcoholic. Alcoholism rarely appears in one person set apart from others.

It seldom continues in isolation from others. Therefore, to understand alcoholism and 'denial', we must look not merely at the alcoholic but also at others closely related to him. For the alcoholic to maintain his 'denial', others contribute unknowingly.

If excessive drinking continues for a long time, it inevitably leads to a crisis, where the alcoholic gets into trouble and will end up in a mess, if only others are not there to support him. This can happen to each individual in a different way. But the pattern always remains the same.

Alcohol, which at first gave him a sense of success and independence, has now exposed him and made him a helpless, totally dependent child. Now, everything is taken care of by others.

He behaves as if he is independent when all the while he is totally dependent on others; and drinking makes it very easy for him to convince himself that this is true. The adverse consequences of his drinking always make him more and more dependent on others. When he gets into a crisis, he waits for somebody to take up the responsibility and cover up the consequences; thereafter he ignores the crisis and walks away from it.

The people who protect are referred to as the **Enablers,** the **Victims**, and the **Compensators.** Their behaviour is called **'Enabling Behaviour'.**

''Enabling'' is a therapeutic term which denotes a destructive form of helping. Any act that helps the alcoholic to continue drinking without suffering the consequences of his inappropriate use of alcohol is considered 'Enabling Behaviour'.

The Enabler

The Enabler is a person who may be impelled by his own anxiety and guilt to rescue the alcoholic from his problems. He wants to save the alcoholic from the immediate crisis, and relieve him of the tension created by the situation. To the enabler, it is like saving a drowning man. This rescue mission conveys to the alcoholic what the person really thinks, ''You cannot face your problems without me.''

In reality, the 'Enabler' is meeting a need of his own, rather than that of the alcoholic, although he does not realise it himself. The enabler actually reveals a lack of faith in the alcoholic's ability to take care of himself, which is a form of judgemental condemnation.

This role is normally played by the 'doctors', or 'social workers' who lack scientific information about alcohol or alcoholism which is essential in helping alcoholics out of their problems.

The behaviour of these people conditions the alcoholic to believe that there will always be a protector, who will come to his rescue, even though these enablers insist they will never again rescue him. They have always rescued him and the alcoholic knows that they always will. Such rescue operations are as compulsive to them as drinking is to the alcoholic.

Victim

The victim is usually the boss, the employer, the supervisor or a co-worker. When the alcoholic fails to perform his job, the 'victim' normally completes the work. If the alcoholic is absent due to his drinking or due to a hangover, the 'victim' gets the work done for him.

Statistics in industries show that by the time drinking interferes with a man's job, he may have been working for the same company for quite a number of years, and his supervisor or boss, by now would have become his real friend. Protection of a friend is a perfectly normal response.

The victim always hopes that this will be the last time that he will be rendering this sort of a help. But he continues to protect the alcoholic again and again.

The alcoholic becomes completely dependent on this repeated protection and cover-up by the victim. Otherwise he will not be able to continue drinking in this manner.

In short, it is this 'victim' who unknowingly helps the alcoholic to continue with irresponsible drinking without losing his job.

The compensator

The key person is normally the wife or parents of the alcoholic, or the person with whom the alcoholic lives. This person has played the role of 'compensator' much longer than anybody else.

The wife is hurt and terribly upset by his repeated drinking episodes. She has to take up the responsibility to hold the family together in spite of all the problems created by drinking. She becomes bitter, resentful, afraid, and deeply hurt. She controls, sacrifices, adjusts, but never gives up. The alcoholic blames her for everything that goes wrong in the house, or outside.

In helping the alcoholic, she also unconsciously meets a need of her own. She enjoys her inevitability arising out of the alcoholic's total dependence on her.

She is also forced to play the role of a responsible and accommodating housewife, who can function efficiently in spite of the problems surrounding the entire family. She is afraid that society will otherwise brand her as 'non-cooperative, unaccommodating and inefficient'.

She tries whatever is possible to make her marriage work and to prove that she is able to manage her problems efficiently. She plays all the roles — the role of a wife, the role of a father, the role of an earning member and so on.

When an alcoholic gets into trouble, her typical response is to try and minimise it.

"Let us hush this up!"

"Let me inform his office that he is taking leave because there is a function at home!"

These are moments when he is drunk. These are the ways the compensator minimises the force and the pain of each crisis as it develops. While they are trying to be helpful they are actually aiding and abetting the development of the disease. Everytime they try to rescue an alcoholic, they are only postponing the necessary treatment.

Living with a man with the disease of alcoholism, she tries to learn, and counsel him as well.

As a result of this, she hurts herself, adds more guilt, bitterness or hostility to the situation which in the course of time becomes unbearable.

If the alcoholic is rescued from every crisis either by the Enabler, the Victim or the Compensator, there is no chance for the alcoholic to recover at all. Long term recovery is possible only if the major block, namely **denial,** is broken.

In reality, the alcoholic is helpless; by himself he cannot break the lock. He will recover only if the above mentioned people learn to break his dependency on them by refusing to help him get out of the crisis created by his alcoholism.

The alcoholic will feel helpless and desperate because some crisis or the other will inevitably occur due to his excessive use of alcohol. He will find no one ready to take up responsibility for his actions. He will find it impossible to deny the problems associated with his use of alcohol and it is the crisis that will force him to come for help in despair.

The Enablers, the Victims and the Compensators, too, must seek information, insight and understanding if they plan to change their roles, so that the alcoholic's denial is broken and he realises the need for help.

They should realise that: -

— 'Denial' is the result of the social stigma attached to alcoholism; the alcoholic's defense mechanism and the 'enabling behavior' of the people significant to him.

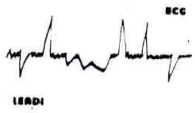
— A Crisis is an opportunity — it need not be terrifying.

— The problem is to get people knowledgeable enough to use it creatively, i.e., out of crises, develop opportunities for intervention.

— The resulting confrontation following a crisis can break through denial and this will be the first step towards recovery; — perhaps even the beginning of treatment.

— The task of treatment is to make the alcoholic well. But, it is the task of intervention to bring him to treatment.

Value additions place



— Diagnostic tool

Different methods of denial adopted

Simple denial	Denying the existence of any problem whatsoever associated with the use of drugs/drinks.
Minimising	Underplaying the extent of the problem.
Blaming or projecting	Holding others responsible for one's own shortcomings.
Rationalising	Finding excuses and justifications for one's inappropriate use of alcohol.
Intellectualising	Attempting to avoid facing any alcohol-related problem by looking at it theoretically.
Diverting	Totally changing the subject of conversation whenever it focuses on the use of drugs or drug-related problems.
Hostility	Displaying anger and irritability.
Silence	Not responding verbally to any provocation.

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9

CAUSATIVE FACTORS*

Causes of Alcoholism

The search for a unitary cause of alcoholism has shifted to inter-disciplinary exploration of factors that might, individually or collectively, account for the development of problem drinking in various types of individuals. Although there is no generally agreed-upon model of how alcoholism starts, research into the physiological, psychological, and sociological factors has resulted in a far greater understanding of the conditions that may precede, underlie, and maintain problem drinking. The state of knowledge is still quite crude. There have, however, been several promising leads which may ultimately contribute to better prediction and protection of individuals likely to develop alcohol problems, and to improved treatment techniques for those already ill.

Physiological theories

Despite considerable research efforts to find physical factors, either in alcohol itself, or in the biological makeup of those who drink, which could account for alcoholic drinking and addiction, to date, many of the questions remain unsolved. Some of the proposed theories are presented here for consideration, including the genetic, endocrine, and genetotrophic theories.

Genetic theory

Some workers in the field theorise that alcoholism may be inherited. Alcoholism appears to run in families; it is therefore, suggested that an alcoholism prone individual may have inherited a susceptibility to be influenced adversely by ingested alcohol. Research has provided some evidence to support this theory. The possibility that humans may inherit a predisposition for alcoholism or an immunity to it does not rule out other factors also contributing to its occurrence in a positive or negative manner. Thus, the development of alcoholism may be the result of a collection of factors rather than just one.

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* This chapter has been reproduced from: Comprehensive Health Education Foundation, Here's Looking at you Two — A teacher guide for Drug + Alcohol Education, CHEF, Seattle, USA, 1982.

Endocrine theory

Another major physiological theory of the cause of alcoholism indicates a dysfunction of the endocrine system. Similarities between the symptoms seen in alcoholic patients and in patients with endocrine disorders suggest that some failure of the endocrines might be causally related to the onset of alcoholism. If alcohol ingestion stresses the organism, chronic heavy drinking could cause a hyperactivity of the pituitary gland, eventual exhaustion of the adrenal cortex, and consequently, a breakdown in the functions regulated by the adrenal hormones.

As with other theories, the experimental clinical evidence to date is not conclusive. The available information suggests that the endocrine characteristics associated with alcoholism may be a result of chronic heavy drinking rather than its cause.

Genetotrophic theory

The genetotrophic theory of alcoholism combines the concept of a genetic trait and nutritional deficiency. It is postulated that, due to an inherited defect or 'error' of metabolism, some people require unusual amounts of some of the essential vitamins. Since they do not get these unusual amounts in their normal diet, they have a genetically caused nutritional deficiency. Those who drink alcohol develop an abnormal craving for the substance, and the consequence is alcoholism.

Other physiological theories

Other physiological theories about alcoholism include factors such as allergies, differing metabolic rates, and non alcoholic components of alcoholic beverages (congeners). Although there is a theoretical basis for each, the scientific evidence does not yet exist to support them.

In summary, it is generally held that physiological factors probably contribute to the development of alcoholism, but none has yet been conclusively proven to be the single cause.

Psychological theories

Some researchers believe that individuals with alcohol problems possess a number of distinctive traits which together make up the 'alcoholic personality'. However, there is no agreement on the identity of these traits, nor on whether they may be the cause or the result of excessive drinking. Three approaches to the psychological cause of alcoholism are explained in this section. The psychoanalytic theory, the learning theory and the personality trait theory.

Psychoanalytic theory

Psychoanalytic explanations of the causes of alcoholism rest on three major theoretical positions.

a) The Freudian view
b) The Adlerian view
c) The view that alcoholism develops as a response to an inner conflict between dependency drives and aggressive impulses.

The Freudian view as expressed by a number of people relates alcoholism to such factors as repressed urges, oral dependency, need for security, self-punishment and parental hatred.

The Adlerian view is that alcoholism represents a striving for power, which compensates for a pervasive feeling of inferiority. It is assumed that alcoholics derive their feelings of inferiority from a childhood in which overindulgent parents did not permit them to learn how to cope with the problems of adult life. The alcoholic turns to alcohol to enhance his feelings of self-esteem and prowess.

Other studies suggest that frustrated ambitions may play a role in the development of an alcohol problem. It is suggested that alcoholics may have an enhanced need for power, but find themselves inadequate to achieve their goals. They resort to alcohol because it provides a sense of release, a sense of power and feelings of achievement. Since overindulgence in alcohol precludes effectively coping with the existing problems and leads to additional problems, this vicious cycle results in confirmed alcoholism.

Evidence to support the psychoanalytic views is inconclusive, since it is difficult to devise experimental tests of these theories. Nevertheless, in some cases, the application of psychoanalytic ideas in the treatment of alcoholism has been successful.

Learning theory

The learning and reinforcement theory explains alcoholism by considering alcohol ingestion as a reflex response to some stimulus and as a way to reduce an inner drive such as fear or anxiety. This theory holds that persons tend to be drawn to pleasant situations or repelled by unpleasant or tension-producing ones. In the latter case, alcohol ingestion is said to reduce the tension or feelings of unpleasantness and to replace them with a feeling of wellbeing or euphoria.

The obvious troubles experienced by alcoholics might appear to contradict the learning theory in the explanation of alcoholism. The discomfort, pain, and punishment they experience should presumably serve as a deterrent to drinking. The fact that alcoholics continue to drink in the face of family discord, loss of employment, illness and other sequels of repeated bouts is explained by the fact that alcohol has the immediate effect of reducing tension while the unpleasant consequences of drunken behaviour come only later.

The role of punishment is becoming increasingly important in formulating the cause of alcoholism based on the principles of the learning theory. While punishment may serve to suppress a response, experiments have shown that under some circumstances it can serve as a reward and reinforce the behaviour. Thus if the alcoholic has learned to drink under conditions of both reward and punishment, either type of condition may precipitate renewed drinking.

Ample experimental evidence supports the hypothesis that excessive alcohol consumption can be learnt. However since conflicting studies exist, the learning theory requires further research.

Personality trait theory

Psychological research has also attempted to define the causes of alcoholism in terms of an 'alcoholic personality'. Though it is conceded that all alcoholics need not have the same characteristics, it is postulated that in the pre-alcoholic stage, a personality pattern or constellation of characteristics should be discernible and should correlate with the pre-disposition towards alcoholism. One of the main difficulties in this approach is that the population ordinarily available for study is already in trouble with alcohol. The question is whether the personality traits observed in these people predate the onset of alcoholism, or are a consequence of alcoholism.

Using objective and projective tests, researchers have attempted to identify an underlying personality disorder. As yet, these approaches have failed to identify a common personality structure of the alcoholic patient which would be predictive of alcoholism. There is evidence that alcoholic patients exhibit some personality traits in common. Once the addiction has been established, these patients show some common behavioural and trait manifestations which appear to be more relevant to alcoholism than to other psychological disorders.

Sociological theories

Alcohol serves vastly different functions within and among societies, cultures, subcultures, and ethnic and religious groups. Attitudes concerning its use range from extreme permissiveness to absolute abstinence. But abstainers can always be found when permissiveness is the watchword, and, conversely, drinking does not disappear when abstinence reigns. The purposes for which alcohol is used include religious, culinary, psychic, ceremonial, hedonistic, traditional, social and medicinal ones. Standards of acceptability applied to the manner or pattern of drinking vary according to the age, occasion, sex, cultural background, social class and the particular circumstances.

Cultural theory

The cultural theory of alcoholism suggests that within a given society, there are three ways in which the culture may influence the rate of alcoholism.

a. The degree to which the culture operates to bring about inner tensions or acute needs for adjustment in its members.

b. The attitudes towards drinking the culture produces in its members.

c. The degree to which the culture provides suitable substitute means of satisfaction.

Societies may provide alternatives to or substitutes for alcohol use. Some societies have less stringent sanctions against narcotic drugs and therefore have a lower alcoholism rate. Others permit emotional outlets through ceremonies and rituals and thereby provide a culturally accepted means of anxiety reduction.

Deviant behaviour theory

Depending on the context, the use of alcohol can be illegal or only illegitimate... acceptable or even sanctified...forbidden or abominated. Thus, the concept of alcohol abuse as deviant behaviour is receiving increasing attention by researchers. The deviant behaviour theory represents the alcoholic as someone who, through a set of circumstances, becomes publicly labelled a deviant and is forced by society's reaction into playing a deviant role.

A Summary of the Causes of Alcoholism

The search for a single cause of alcoholism may be an unrealistic goal. Nevertheless, researchers with specialised interests and with needs to define alcoholism from their own perspectives will probably continue to look for a unitary answer to solve the problem of how alcohol addiction occurs and to identify the crucial factors associated with its onset and progression.

Many theorists, however, suggest a multifaceted approach which incorporates elements from two or more hypotheses. Generally, such an approach selects from each of the broad areas discussed — physiology, psychology and sociology.

An individual who (1) responds to beverage alcohol in a certain way, perhaps physiologically determined, by experiencing intense relief and relaxation; and who (2) has certain personality characteristics, such as difficulty in dealing with and overcoming depression, frustration, and anxiety; and who (3) is a member of a culture that induces guilt and confusion regarding what kinds of drinking behaviour are appropriate, is more likely to develop trouble than most other persons.

More research will have to be done to gain a deeper insight into the causes of alcoholism. Work is needed to identify better the association between alcohol use and all aspects of physiological responses, predispositions and attitudes, and the social context and consequences of drinking.

Causes of Drug Dependence

In any general discussion of drug dependence, the use of substances which produce several different and even contradictory effects are included together. Researchers in the field have abstracted three main areas within which to explore the causes of dependence: the physiological, the psychological and the sociocultural.

Physiological theories

Physiological explanations for the causes of drug dependence have attempted to relate the pharmacology of particular drugs to some physical effect or change in the individual using the drug. This approach has led to two types of hypotheses: 1) that dependence may be the result of an inherited predisposition or genetic factor(s), and 2) that dependence may result from a drug-induced alteration in the body's physiological functioning.

There are some indications that substance dependence may be genetically transmitted or encouraged. Alcoholism or drug dependence is frequently found among the parents or relatives of drug dependent individuals, leading to the suggestion that there may be some inherited inability to control psychoactive substances. The genetic factors have received some more support from the recent discovery of naturally occurring opiate-like compounds — endorphins — in the brain. This discovery has led to the exciting although wholly undemonstrated hypothesis that lower than normal levels of these compounds stimulates a need for self-medication, and facilitates the development of opiate dependence. Unfortunately, no similar natural compounds have been isolated which correspond to other psychoactive substances. Also, it is not known what the impact of environment is upon genetics as it relates to the drug field.

Physiological adaptation to a particular drug which is not reversible by detoxification or withdrawal has been a primary focus of research which attempts to understand why drug dependent individuals relapse and show continued craving for the dependency producing substance. One possibility proposed for the opiates, and leading to the establishment of methadone maintenance programmes, is the theory that physical dependency or extensive use of an opiate results in a biochemical change in the individual's system, not reversed by detoxification, and only relieved by continued ingestion of opiates. No physical evidence for this theory has been found, although the success of the methadone maintenance programmes lends it some support.

Other types of drugs, such as the amphetamines and different hallucinogens have been implicated in theoretical approaches which propose that continued use stimulates the reward centres in the brain in such a way that a craving for ongoing administration of the drug is established physiologically. We still know too little about the normal brain and its functions, and too little about the precise ways in which different drugs affect these functions, for any of these adaptational theories to be more than provocative hypotheses at this time.

Psychological theories

A search for the common factors in the drug dependent personality has long been a topic of research for the field of psychology. This **psychoanalytic approach** to drug dependence is dominated by the idea that persons with drug dependence do share certain psychological characteristics which comprise the "addictive personality". Proposed personality characteristics linked to drug dependence include unresolved dependency needs, escapism, low self-esteem, compulsiveness, and a lack of internal control. Changes in these factors have had some correlation with success in treatment. It remains uncertain, however, whether these personality characteristics are not mere side-effects and results of the drug-dependent lifestyle and orientation, psychological adaptations as it were, than representatives of any pre-disposing pattern. It is reasonable to suppose that some personality characteristics may make a person more susceptible to drug dependence than others, but how these characteristics interrelate, and why similar persons do not become drug dependent have not been satisfactorily explored.

An alternative psychological approach is one which does not seek to identify distinct personality characteristics, but rather attempts to consider the responses of the individual to certain drug or drug-related stimuli, and the way these responses become habitual or produce dependency.

Behaviorist theories, applied to drug dependency, attempt to characterize how users who learn to enjoy the effects of a particular substance may continue to use that substance both because of the learned positive effects, such as euphoria, and to avoid the learned negative effects, or withdrawal. Similarly, many drugs are thought to have an instrumental or reinforcing effect which leads to continuation of use and dependency. The reinforcement for use is thought to be the reduction in fear, stress, anxiety, or conflict which drugs may provide, and thus the drug dependency may be a functional adaptation for the individual in a personal sense despite adverse consequences in other areas. This stimulus-response approach to the causes of drug dependence leads to powerful explanations, although some professionals view that as an over-simplification of the dependency process.

Sociocultural theories

As with the previous theories, there are two aspects of dependence examined through the sociological approach. Researchers are both examining the social and cultural bases for the onset of dependence, and describing those social and cultural factors which contribute to the perpetuation of dependence.

In the theories of social deprivation, relative deprivation, and anomie, individuals were thought to turn to drug use and eventual dependence as a result of the conditions in their social environment which denied them opportunity for achievement. While fitting fairly closely some conditions of minority drug dependence, these approaches have little explanatory power for the present generation of middle-class, Caucasian abusers except in the broader sense that these individuals may also experience social frustrations.

Other explanations for the causes of drug dependence rest on the observed examples of drug use as a statement of protest and separation from mainstream values, and the support of this separateness by some peer groups. The concept of peer pressure has attained major importance in our understanding of why individuals engage in deviant behaviour such as drug use.

The second aspect of the sociocultural approach explores the manner in which the larger environment may support the continuation of substance use and foster dependency. American society, by generally viewing as desirable and necessary the use of drugs for relief of life's pain and enhancement of life's pleasures, tends to provide a singular climate for all forms of drug dependency. Countering this climate of support is the stigma associated with illicit drug use and drug dependence. The concept of **deviance labelling,** in which the individual through his/her use of non-permitted substances in non-permitted ways becomes labelled as deviant, attempt to explain drug dependence as an outcome of this labelling. Through the labelling process,

and society's responses to the labels, the drug use becomes the most important aspect of the individual's life due to the exclusion by society of other alternatives.

Researchers have also examined the ways in which the immediate environment of the substance user, referred to as a **subculture**, supports and reinforces drug dependency through provision of a structure and a sense of community. The drug subculture both attracts new users and retains more experienced users through its own attractiveness, and through the reduction of other life styles due to their drug dependence. The subcultural perspective may further explain the return to use after treatment or detoxification, since for many persons, it is the only life style in which they can find a sense of belonging, and in which they can succeed.

Summary

All of the above theories overlap frequently in several ways, with terminology being the major difference among them. Since no single theory proposed thus far can account for the physical, the psychological, and the sociocultural aspects of becoming and being drug dependent, some professionals are now examining the interaction of their theories as an explanation of dependence.

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ADDICTION – THE ROLE OF PARENTS

Research has shown that one of the causative factors of chemical dependency is a 'strained relationship' in the family, — especially between parents and children.

Any programme which aims at prevention of chemical dependency should therefore include parents as their target group. Educating and creating awareness about effective parenting would help develop a healthy and positive parent-child relationship. This would pave the way for their child's untroubled, addiction-free adult life.

Building a relationship

A healthy family relationship includes sharing, open communication, honest expression of feelings, warmth, understanding and active participation in each other's interests.

The following are some of the guidelines towards 'positive parenting'.

★ Parents should make the child feel that his participation in the family activities is valuable. For example, when the child helps in cleaning the house, watering the plants or buying provisions/vegetables, parents should express their satisfaction and appreciate the contribution made.

★ Parents should learn to recognise the child's strengths and encourage him to work to the best of his ability.

★ Parents should regularly allot time, to spend with their children. Parents should express sincere interest in their child's activities — studies, games, other interests, etc.

★ Parents should get interested in their child's friends and establish a warm and cordial relationship with them.

★ Effective communication begins with the parent's commitment to listening. Listening involves attending to whatever the child has to share regarding his experiences at school, problems with other children, joyful moments, ambitions etc. Parents should make eye contact with the child while listening. By listening, parents make the child realise that they do appreciate the child's point of view.

	Yes	No
28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?	—	—
29. Have you ever felt sick, cried, or had a 'knot' in your stomach after worrying about a parent's drinking?	—	—
30. Did you ever take on any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?	—	—

Interpretation

If the child has given 6 or more 'yes' answers, it means that this child is likely to have an alcoholic parent.

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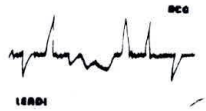
	Yes	No
10. Did you ever feel like hiding or emptying a parent's bottle or liquor?	—	—
11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking.	—	—
12. Did you ever wish that a parent would stop drinking?	—	—
13. Did you ever feel responsible for and guilty about your parents drinking?	—	—
14. Did you ever fear that your parents would get divorced due to alcohol misuse?	—	—
15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?	—	—
16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?	—	—
17. Did you ever feel that you made a parent drink alcohol?	—	—
18. Have you ever felt that a problem drinking parent did not really love you?	—	—
19. Did you ever resent a parent drinking?	—	—
20. Have you ever worried about a parent's health because of his or her alcohol use?	—	—
21. Have you ever been blamed for a parent's drinking?	—	—
22. Did you ever think your father was an alcoholic?	—	—
23. Did you ever wish your home could be more like the home of your friends who did not have a parent with a drinking problem?	—	—
24. Did a parent ever make promises to you that he or she did not keep because of drinking?	—	—
25. Did you ever think your mother was an alcoholic?	—	—
26. Did you ever wish that you could talk to someone who could understand and help you solve the alcohol related problem in your family?	—	—
27. Did you ever fight with your brothers and sisters about a parent drinking?	—	—



— Diagnostic tool

Children of Alcoholics Screening Test

The CAST developed by John W Jones, Ph.D., is a valid and reliable screening test that can be used as an aid to identifying children of alcoholics. The questionnaire consists of 30 questions that describe the feelings, behaviour and experiences related to a parent's alcohol abuse. The child is asked to answer all 30 questions by marking either 'yes' or 'no' in a way that best describes his/her feelings, behaviour and experiences related to his or her parents' drinking.

Please check the answer below that best describes your feelings, behaviour, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by ticking 'yes' or 'no'.

Sex: Male ..... Female ..... Age: .....

	Yes	No
1. Have you ever thought that one of your parents had a drinking problem?	—	—
2. Have you ever lost sleep because of a parent's drinking.	—	—
3. Did you ever encourage one of your parents to quit drinking?	—	—
4. Did you ever feel alone, scared, nervous, angry or frustrated because a parent was unable to stop drinking?	—	—
5. Did you ever argue or fight with a parent when he or she was drinking?	—	—
6. Did you ever threaten to run away from home because of a parent's drinking?	—	—
7. Has a parent ever yelled at or hit you or an other family member when drinking?	—	—
8. Have you ever heard your parents fight when one of them was drunk?	—	—
9. Did you ever protect another family member from a parent who was drinking?	—	—

Sometimes I also cry. I cry when I see daddy vomit or fall; I cry when he scolds or beats me for no fault of mine.

Suddenly mummy shouted, "Go to your room!

"It is not bedtime! Why is she asking me to go to bed? This happens every day — again and again — especially when I ask her anything about daddy... But why?!...

Little Ram had a terrible time with my father the other day. He said that his friend called my father a 'drunkard'. My father slapped him and said, "Don't you ever use that word in this house!" We agreed with him silently. After all, it is a dirty word.

Mummy shouts when daddy doesn't go to work. She gets angry and they start fighting. What can we do? we also cry. When she is worried, she yells at me, at Ram, at Mohan — at everyone around.

I love my father; I love my mother; but I hate the smell that comes from daddy. I wish mummy did not cry all the time; did not blame my father for everything. She cries and shouts; never answers any of our questions; she does not have any time to talk to us or even sit with us.

Last week, daddy promised to take us to a movie. We waited till late in the evening. He never came back from the office. When he came home, he was not walking straight. It was too late and he went back to sleep. He never spoke to any of us.

This is not the first time that he has broken his promise.

Mummy also never keeps her promises.

She says daddy forgets because he drinks. She does not drink at all. How is it that she also forgets everything? One fine day, she bought me a toy and a ball. I had never asked for it.

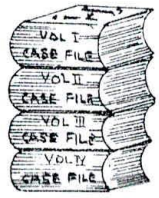
We do not want a ball. We do not want any toys. We want to sit with them; play with them; talk and eat with them; go out with them...! We want love; we want affection. Will we ever get it at all?!

We want hugs; we want love — we do not want toys! We want our daddy to get well soon. Only then can we all go together to movies, to the beach, to the zoo... to our grandparents' house...

Will he get well? Can we talk, laugh and enjoy?

I am terribly scared. I am afraid daddy will hurt mummy, and mummy in turn will hurt us.

I want to shout, "We hate all of you!" and run away as far as possible from this house ....BUT...WHERE?!!



— A Case Study

The secret cry of a child

Mummy looked very sad. She did not answer.

"Is something wrong with my house?... It appears to be a very nice house!... Daddy has a good job!... But why is it that there is always yelling at nights in my parent's bedroom?

Again I asked mummy, "What is 'drunk', ma?"

Mummy turned — "Why do you want to know?"

Karthik said, "Your daddy is a 'drunk'..." what does that mean, ma?

She did not speak. Suddenly she said, "Your daddy drinks a lot. He seems to like the way it makes him feel, and he does not stop drinking even though it makes him sick."

"When I start eating cone ice-cream, I eat right down to the end. Even after that, I feel like having some more. Does daddy feel the same way when he drinks?"

Mummy kept quiet. She was crying.

'Mama, why don't you ask daddy not to drink so much? Then he won't get sick. You make him stop drinking."

Mummy continued to cry — did not talk to me.

Nowadays, mummy is always in bed with some illness. It never seems to go away. I do not even invite my friends to come and play in my house.

I think daddy is really sick. He is sick because he drinks a lot... But what is wrong with mummy? Why is she always sick?

Is something wrong with my mummy also?... But I don't see her drink!! She always either cries or shouts. I am unable to understand anything. I am confused.

I don't tell even my dearest friends as to what is happening in my house. I feel so alone; no one understands me. Mummy says that I should not speak about my daddy's drinking to anybody — not even to my grandpa. Even we brothers do not talk about it between ourselves... But why?!

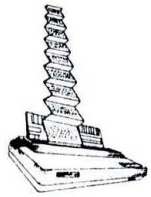
The most significant characteristics of the fetal alcohol syndrome include mental retardation, poor movement coordination (especially fine motor movement), and growth deficiency (such children tend to have low birth weights and continue to remain small throughout childhood despite adequate caloric intake). These children also tend to show a characteristic facial appearance (such as small head circumference, short eyeslits, low nasal bridge, short upturned nose, thin upper lip etc).

Obviously, many of these facial features are not unique to the fetal alcohol syndrome, but occur commonly in other children. It is the clustering of these facial features (along with mental retardation, poor motor coordination, and growth deficiency) in children of alcoholic mothers that makes the features part of the fetal alcohol syndrome.

Originally we doubted that fetal exposure to alcohol itself was the cause of the fetal alcohol syndrome. Some investigators thought the syndrome might be due to nutritional deficiencies in the mother that are often associated with alcoholism. Others thought the syndrome might be related to cigarette smoking, a practice that is also common among alcoholics. Still others thought it might be related to other medication that physicians sometimes prescribed for pregnant women. While all of these practices in their own right may have detrimental effects on the fetus, it is now clear that alcohol itself is capable of producing the effects that are seen. This conclusion has come primarily from animal research, where exposure to smoking, diet, and other drugs in the developing fetus can be experimentally controlled. A number of animal studies have shown that alcohol itself is capable of producing symptoms that closely resemble those seen in the fetal alcohol syndrome in humans.

Since its original description in 1973, the existence of the fetal alcohol syndrome has been verified by a large number of medical studies. While the disorder seems to be limited to children of chronic alcoholic women, not all chronic alcoholic women have children with fetal alcohol syndrome. In fact, only a minority do. Several recent studies have found that 26-33% of the children born to chronic alcoholic women show evidence of the fetal alcohol syndrome. In no case has the syndrome been found in children of non alcoholic women or in children of women who used alcohol moderately. The disorder apparently does not develop in children of alcoholic men (unless their wives also happen to be alcoholic), since it involves the direct action of alcohol on the fetus of the pregnant woman."

Value additions place



— Additional information

Fetal alcohol syndrome*

The fetal alcohol syndrome is a disorder that affects the infant whose mother had been taking alcohol excessively during pregnancy.

"In pregnancy, the devleoping fetus is particularly vulnerable to the substances it receives from its mother's bloodstream. Receiving a sufficient amount of a large number of substances from the mother is important for proper growth and development of the fetus. At the same time, however, a placental barrier prevents many harmful chemicals taken by the mother from crossing into the fetal bloodstream and affecting the growth and development of the fetus. Unfortunately, the barrier is not successful in keeping all such chemicals away.

Chemicals crossing the placental barrier can have two effects on the fetus. One is the same effect that the chemical has on the mother. That is, if the substance produces sedation and calming in the mother, it will produce sedation and calming in the fetus as well. This effect is temporary and is limited to the time the chemical is in the body of the fetus. The other effect, however, occurs only in the fetus. If the substance crosses the placental barrier, it can alter the developmental process of the fetus, producing abnormalities that will later be evident in both the physical structure and behavioural functioning of the child.

Originally researchers thought the developing fetus was protected from harmful effects of alcohol by the placental barrier. Now we know this is unfortunately not the case. Alcohol readily crosses the placental barrier and enters the fetal circulatory system shortly after the mother begins drinking. In the body of the fetus, alcohol has an intoxicating effect, just as it does in the mother's body. In addition, we have recently begun to recognise that alcohol taken by the mother also has the capability of altering the developmental process of the fetus. Sometimes this produces a classic set of defects in the infant known as the fetal alcohol syndrome. Although this is not the only detrimental effect of drinking on the developing fetus, it is one of the most clearly recognised.

* Reproduced from Roy W Pickens, 'Children of Alcoholics'', Hazelden Publications.

- They feel responsible for so much because the people around them feel responsible for so little.
- The children of alcoholics are pathetic victims of alcoholism. They do not drink, but are victimised by alcohol. They go through the pain and agony without the anaesthetising effect of alcohol.
- These children are victims struggling desperately to get away from their hurt and confusion. These innocent victims need an enormous amount of understanding, comfort, care, information and above all, supportive psychological treatment.

But none of these things ever happend — They were **all only Lies.** The declaration next morning would always be 'I will do it later, not now!'.

The 'later' never came, therefore, the message to this child is, 'forget it — do not believe anyone — do not **trust** anybody!'.

Don't Feel

These children do not have a model to identify feelings. Parents suppress their feelings, and cease to discuss them and the children have no opportunity to develop an adequate vocabulary of 'feeling words' to describe their emotions.

There is no model whatsoever for appropriate emotional expression, and there is an implied negative judgement on the feelings themselves. Often, as the tension increases at home, the implied judgement becomes overt. Children are instructed not to talk about their fathers' drinking and not to talk about its problems and consequences. Direct reprimands for expression of feelings are also common.

These reproofs are always preceded by an emotional eruption and they serve not only to restrict the expression of the child's feelings, but also to label the feelings wrong, inappropriate and destructive. Initially, the child learns that expressing feeling is wrong. The child eventually ends up believing that feelings itself are wrong.

> *John joyfully said,*
>
> *'I have got the highest marks in English. My teacher was very happy!'.*
>
> *The already upset, confused, grief-stricken mother showed no sign of happiness. She did not acknowledge his efforts or performance. Instead, she shouted, 'You are unaware of the struggle I am going through because of your 'blessed' father. Do I have any time at all to think about you, your school, or your exams?''*

The child instinctively learns that he cannot share his feelings with either his alcoholic father or his tired mother.

The child also learns that an expression of feelings will be met with disapproval, hostility, or rejection. In order to avoid what can only be viewed as punishment, the child learns to suppress his feelings.

We must remember that the alcoholism syndrome produces only particular kinds of **behaviours**, and not particular kinds of **people**.

- The children of alcoholics get so absorbed in other people's problems, that they do not have the time to identify or solve their own.
- They care so deeply, and often so destructively, about the problems of people surrounding them, that they always forget how to care about themselves.

Meena's English Exams were the following day. When she was about to go to sleep, her father entered the house thoroughly intoxicated. He had been run over by a cycle and was injured.

Meena's mother was upset and started shouting at her drunken husband.

Meena was panic-stricken. She immediately cleaned her father's wound, fed him, and put him to sleep. She sat up the whole night attending to her father's needs.

The next day her eyes were red, swollen and droopy. When she entered school, her best friend, Renu asked her,

'Meena! Are you not well? You look very dull and sickly today. What is wrong with you?'.

Meena automatically replied, 'I am quite alright. I studied till midnight. My eyes are puffy because I didn't sleep well.'

She walked away desperately, even though in her heart of hearts she wanted to cling to Renu, wanted to open out and say, 'Oh! It is so terrible at home... I am not really sure what is wrong, but I know that something is drastically wrong. Please ... Please help me!'.

She wanted someone to understand without her having to tell them; but she knew no one would.

Meena is **alone** *with her pain. She does not share her problems with anyone. Though her memory is painful, she feels that sharing the real problem will be worse. It will amount to letting her family down.*

"I will **not talk** *or disclose anything. Let me suffer my pain all alone."*

Don't Trust

Children of alcoholics never develop trust because the behaviour of their parents is inconsistent and unpredictable. They always hear only lies and broken promises. There is absolutely no visible model of trust. There is no comprehension of trust as a value. On the other hand, trust is always seen as a trick or a trap.

The parents never provide physical, emotional or psychological support to their children. They never do what they promise to do.

All along, Rekha's father had made many promises.

'I will take you for a movie on Saturday!'

'I will buy you a new dress!'

'Today I will come home early for dinner. We will all eat together!'

'I will clear all your doubts in Physics today!'

They learn that the expression of any feeling is wrong, and will be met with disapproval, hostility, or rejection. In order to avoid this sort of punishment, they learn to suppress their feelings.

They are often confused with being 'well-adjusted' in the real sense of the term or being unaffected by the family chaos. The adoption of artificial behaviour is not conducive to full emotional development, no matter how good it looks.

Such children when they grow up, become the victims of manipulation of people around them. They cannot assert themselves even when aware of being manipulated. They, therefore, get victimised in many ways at home, in their place of work and in other social interactions.

The placating child

The 'placator' goes one step beyond the 'adjuster'. He anticipates the problems of others around him and tries to help them out, unmindful of getting hurt in the process.

This child is always busy taking care of everyone else's emotional needs. The child assists his brother in not feeling hurt or disappointed. This child **intervenes** and ensures that none of the children are too frightened after a 'screaming scene' at home. This is a warm, sensitive, listening, caring child who shows a tremendous capacity to help others. For the placator, the essence of survival lies in taking away the fears, sadness and guilt of others.

Acting out child

Some children in alcoholic homes become very angry at a very early age. They are confused and sacred, and they act out their confusion in ways that get them a lot of negative attention. They normally get into trouble at home, school, and even with their neighbours. These kids keep shouting 'there is something wrong everywhere'. These children end up as rebels, — show delinquent behaviour, throw temper tantrums, and drop out from school.

Three unwritten laws in the home of alcoholics

The children of alcoholics are governed by three unwritten laws

- Don't Talk
- Don't Trust
- Don't Feel

Don't Talk

These children never share or talk freely about anything which happens at home. Any chaotic situation at home like shouting, crying, or even physical abuse will never be discussed with friends, teachers, or relatives.

Responsible child

The resposible child generally takes over the responsibility of the parents. This child provides stability in the family and makes life easier for the parents by looking after the other siblings.

This child is very organised and goal-oriented. He is adept at planning and manipulating others to get things accomplished. He always ensures that others allow him to be in a leadership position. He is often independent, self-reliant and capable of achievements and accomplishments. But because these accomplishments are made not out of choice, but out of a necessity to survive, there is usually a price paid for this 'early maturity'.

For example, the child acts as a parent, takes on household responsibilities and takes care of the younger children. This child cooks and feeds the younger ones in the family and even looks after the father, when he comes back home drunk.

To an outsider, this child will seem to be a remarkable little child. But the truth of the matter is, they just do not see the whole picture. These children nurture and help the adults (the alcoholic father or the non-alcoholic mother) who are playing the roles of incapacitated children. Though these children are not treated with distance, they never come to know what emotional and physical dependence means. Their only source of physical contact with the parent may be picking up their drunken father, washing his vomit, changing his soiled clothing, or carrying him to bed.

Deprived of the nurturing, help, and guidance which they desperately need and legitimately deserve, they are **totally denied their own childhood**, and are given all sorts of impossible tasks. Being loved is confused with being desperately needed, warmth is confused with care taking, spontaneity is confused with irrationality, and intimacy is confused with being smothered.

Adjusting child

The adjusting child learns to adjust and to handle any situation. This child does not think about the situation nor does it outwardly show any emotion as a result of it.

The adjusting child finds it easier not to question, think about, or respond in any way to what is occurring in his life. Adjusters do not attempt to change, prevent or alleviate any situation. They simply adjust — that is, do what they are told. They detatch themselves emotionally, physically and socially as much as possible.

For example, the child would have been promised new clothes to celebrate her birthday. Later on, when the father finds an excuse for not purchasing new dresses, the child simply accepts the excuse and adjusts to the situation. The child has learnt that the best way to maintain peace in the family is by responding to the instructions of others without any questions.

This feedback is normally negative and he internalises these messages. Sometimes the child gets dual messages, one contradicting the other. He does not know which part is true; so sometimes he picks up one part and sometimes the other.

No matter what the child does, it is not good enough. There is always somebody to find fault with him. The child does not believe he is capable of doing anything right, no matter how hard he tries. In short, he feels totally incapable, unworthy, and low.

Depression

It is a depression arising out of 'deprivation'. Parental attention is never focussed on the child. It is always focussed elsewhere. There is actually nobody with whom the child can share his problems. Even the non-alcoholic mother is often not available or too exhausted and depressed to interact with him. The child suffers alone. He learns that when he has a need, there will be nobody for him.

Not only is there the absence of someone to share his problems which is very vital to a healthy childhood development, but also there is extreme anxiety caused when he undertakes a task which requires skill, knowledge and experience much beyond his ability. These children develop pseudo-maturity that covers the **unmet but undiminished needs of childhood**.

The enormity of both the task and its results, the inability to change things, and an unavoidably situation are the causes for chronic depression. This depression inevitably leads to feelings of helplessness, self-pity, self-hatred, isolation and incompetence.

Fear

The children of alcoholics are often treated with the same cool formality and distance with which adults treat each other. There are no cuddles and hugs and the child learns to regard physical warmth with suspicion while simultaneously craving for it. Beneath the mask of self-control, is a lonely, frightened child, hungry for care, warmth and love.

Unable to cope with the enormous problems surrounding them and their family, they are forced to take up certain roles which are either thrust on them, or voluntarily assumed by them.

*Children raised in dysfunctional homes typically play one or more roles within the family structure. These roles may be identified as **The Responsible Child, The Adjuster, The Placator and The Acting Out Child**. With the adoption of each role, there are invariably negative consequences. Most people easily recognise the strengths of the first three roles, but fail to look at the deficits of each role.

Let us analyse how these children are thrust into adult roles.

* This classification of roles has been made by Claudia Black who has been responsible for family programming in 25 alcoholism-treatment centres in the U.S.A. She has done extensive research on the children raised in dysfunctional families, and is a world-wide lecturer and trainer on the subject of 'Children of Alcoholics''.

he is unable to find anything to replace it with. He has not learnt any other method of handling anger and he has rejected the only means he has learnt. So there is a gap in the child's behaviour. This gap inevitably gets filled by passivity and helplessness.

Lying

Children of alcoholics lie when it would be just as easy to tell the truth.

Lying is basic to the family system affected by alcoholism. It starts as a denial of unpleasant realities, cover-ups, broken promises and inconsistencies.

Spouses of alcoholics live with lies and ultimately start telling them. They lie to cover up alcoholism and protect the dignity of the family. Their lying is goal-oriented and begins with a good intention. Lying becomes an adaptive response. The child hears lots of promises from his alcoholic father. All these turn out to be lies. Therefore the child learns that it is alright to tell lies. It will make his life much more comfortable. The value of truth totally loses all meaning.

If they are confronted with the truth, they become genuinely confused, both by the disapproval and by the concept of truth. Their lying does not lead to any guilt because they really see nothing wrong with lies. In fact, they are more likely to feel guilty telling the truth if that truth affects someone important to them. The paradoxical message creates only a confusion and not a desire for honesty.

Denial

Denial takes various forms — denial of problems leads to denial of the feelings produced by those problems.

Honesty, when applied in traumatic situations, will often cause discomfort. Therefore these children learn to minimise, discount, and rationalise for fear of the consequences which are likely to follow if they tell the truth. Often when the child tells the truth, he is told that what he sees and reports is not accurate.

> *"Your father is not drunk. Your father is only depressed. He is sick due to viral fever."*

The parental rationalising and discounting serve as a perfect role model for the child to begin his own rationalising, discounting and denial process.

The suppression of anger is used to avoid a fight; the suppression of hopes to avoid disappointment; the suppression of affection to avoid rejection.

Loss of self-esteem

This child does not feel worthy. He has a very low self-esteem. In order to measure self-esteem, one needs the sense of 'self'. This child, unfortunately does not even have one. He determines what he is by the inputs of the significant people around him.

These children lose their identity — as a matter of fact, they never had an opportunity to form one. They are subject to situational reinforcement and are always trying to please people.

Children of alcoholics as a group, have a higher incidence of emotional problems like anxiety, stress and depression. They also have lots of school problems — difficulty in concentration, conduct problems, and truancy. They experience all sorts of adjustment problems.

In addition to emotional and adjustment problems, severe medical disorders have also been associated with the children of alcoholics — Fetal Alcohol Syndrome, Hyperactive Child Syndrome and a Predisposition to Alcoholism.

'The Fetal Alcohol Syndrome' is a disorder that sometimes occurs in babies born to alcoholic mothers. It results in physical malformation and intellectual impairment of the baby.

'The Hyperactive Child Syndrome' becomes noticeable when the child is about three years old. It is characterised by inattentiveness, lack of concentration, impulsiveness and hyperactive behaviour. These children can easily be distracted and as a result they experience problems at school.

Children of alcoholics show an increased predisposition to abuse of alcohol or other drugs when they enter adulthood.

Problems faced by the children of alcoholics

Lack of Role-Model

No child is born with standards for evaluating behaviour, social skills or moral values. They learn from what they see. In an alcoholic family, they see nothing but guilt, justification, denial, aggression and repetitive negative behaviour. The child has no other experience except possibly being scolded or getting beaten. There is no yardstick to define any situation.

The alcoholic father is sometimes very loving and warm. He is everything one expects a father to be — caring, interested, promising all the things that the child wants. The child feels that he is being loved.

But at other times, the same father is entirely different. Those are the moments when he is drunk. He does not come home at all; the child waits and is worried. When he comes home, he picks up a quarrel and the child is scared. The child does not know what to do. He is uncertain of what is going to happen next, and he feels desperate. The father has forgotten all the promises he made. The child feels strange.

The behaviour of the father teaches the child that anger means violence and that violence and love go together; the child has no opportunity to learn that only tenderness and love go together. If the child rejects violence as a coping mechanism,

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CHILDREN OF ALCOHOLICS

Alcoholism is a family disease which affects not only the alcoholic, but also each and every member of the family living with him. It affects the children with the same intensity with which it affects the spouse, infact even more. Adults can choose their spouses; so they have the option of leaving them. Children have neither the choice nor the mobility to enter into or exit from the parent-child relationship. While the spouse **feels** trapped, the child **is really** trapped. The spouse is emotionally helpless, whereas the child is emotionally and situationally helpless.

When does a child lose his childhood? — when he lives with an alcoholic parent. To others, he looks like any other child, dresses like any other child, and walks about like any other child until they get close enough to notice that edge of sadness in his eyes, or the worried look on his brow.

He behaves like a child — but he is not really enjoying; he just carries on. He does not have the same spontaneity that other kids have. But nobody really notices it. Even if they do, they probably do not understand it.

The fact remains that he never **feels** like a child. He has never known what a child feels like. Any normal child is an innocent, beautiful, delicate being — bubbling with energy, offering and receiving love easily; mischievous, playful, doing work for approval or for reward, but always doing **as little** as necessary. The most important fact is that he is always **carefree**.

In contrast, the child of an alcoholic is not a **carefree** little one — he is often a **withdrawn** child who never gives trouble to anybody. He hides himself in a corner. Though he does not really want to be hiding, he always instinctively hides in a **shell**, hoping to be noticed sometime or the other. But he is powerless to do anything about it.

Children in families with alcoholism syndrome are generally ignored because all the attention is directed either towards the alcoholic parent or towards his alcoholism. The self-centred, uncooperative, destructive behaviour of the alcoholic collects in totality all that the child longs for — **attention**. At the same time, the child learns not to rock the boat, not to develop any desires or needs, not to make demands.

Behaviour/Feelings	Of the patient	Of the family member
15. Acute depression	Caused by excessive/ inappropriate use of chemicals. (Consequence of the toxic effects of the drug on the central nervous system.)	Due to loss, frustration and helplessness.
16. Is a victim	Of chemical dependency.	Victimised "by the chemical" even though she is not using it.

SOMETHING WORTH PONDERING OVER

The chemically dependent person resorts to drugs to 'numb' his feelings and thereby escape from problems and pains.

What about his family member?

She gets victimised by the chemical — but is left to suffer "all alone" because for her there is no anaesthetising agent or "escape route!"

Who suffers more?

Who gets more deeply hurt?

Difficult to answer.... but

Worth pondering over.

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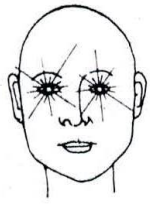
Behaviour/Feelings	Of the patient	Of the family member
7. Denial	Denies the 'problem' totally, or justifies his misbehaviour by holding others responsible.	Totally denies the 'problem' or denies the fact that some problems in the family are a result of her own irresponsible behaviour. Blames him for every problem.
8. Guilt	At times, feels guilty about his own behaviour and makes promises to change.	Wonders whether her inadequacy is the reason behind his abuse.
9. Attempts to change	Attempts to get out of his dependency. (Though unsuccessful, he makes several attempts)	Attempts to change her behaviour; tries to display a caring, warm and affectionate personality; but does not succeed in maintaining it.
10. Avoiding social relationships	Abuses chemicals all alone; becomes totally withdrawn, and avoids society at large.	Stops meeting neighbours, relatives and even her own parents.
11. Ethical breakdown	Begs, borrows or steals (goes to any extent) to maintain his supply of chemicals.	Takes away money from his pocket, so that he will not be able to buy chemicals. (Viewed by her own children as stealing.)
12. Indefinable fear	Afraid that everyone around is going to harm him (paranoia).	Afraid of even minor events; experiences constant lurking fear, due to her internalised emotional stress.
13. Low Self-worth	Feels unworthy and low.	Always feels inadequate — very low self-esteem.
14. Dishonesty	Utters all sorts of lies to 'hide' his chemical dependency.	Tells lies to cover up the consequences of chemical abuse. Utters lies even when it is not at all necessary. Lying becomes an adaptive response.

Value additions place



— Perceptive Findings

Chemical dependency is a disease which affects the family member with the same intensity with which it affects the dependent person. How?

Behaviour/Feelings	Of the patient	Of the family member
1. Preoccupation	waits for the earliest opportunity to use the chemical. "How can I slip away to have a 'quick one'?"	with the behaviour of the chemically dependent person. "My God! What is this person going to do next?"
2. Loss of control	over the quantity, time and place of chemical abuse.	over her own responses and behaviour.
3. Avoiding any talk about the chemical	diverts any talk pertaining to chemicals.	gives instructions even to her children to keep chemical abuse a family secret.
4. Justifying	Justifies his 'use' of chemicals.	Justifies her own irresponsible attitude towards the family — holds the chemically dependent person responsible for each and every problem in the family.
5. Aggression	Verbal/physical abuse	Throws tantrums — sometimes anger becomes misplaced. (Beats the children for trivial mistakes committed by them).
6. Grandiosity	Talks 'big' about himself; gives others much more than what he can afford.	Tries to maintain a personality 'too good to be true', which is incompatible with her abilities. Aims at an 'illusory perfection'.

To conclude,

The chemically dependent person and his family are both hurt, and are facing a crisis. Within the family, there is severe stress, negative feelings and growing problems. The patient needs primary treatment for the disease of addiction and the family members need treatment for their dysfunctional behavioural patterns. Treatment methods may vary but the need for recognition, acceptance and understanding of each member's role in the family disease is absolutely necessary for full family recovery.

Whatever time it takes, recovery is worth the effort. One point is worth repeating **— chemical dependency is a family problem and recovery, a family responsibility.'**

* Family members normally feel reluctant to give up all responsibilities. When the chemically dependent person was abusing drugs, the entire household responsibility centered round the wife or parent. She had all the power in hand. She would have enjoyed the appreciation of relatives and neighbours around regarding her ability to manage the house in spite of the enormity of the problems.

* Once the patient starts recovering, he may start taking up many of the responsibilities previously carried out by the family member, as a result of which her importance is likely to come down. The wife or parent should anticipate this sort of a change and learn to accept it. Apart from this, she should also take extra efforts to involve the dependent person in all family activities.

* During the problematic period, there would have been a lack of proper communication in the family system. There would have been only telegraphic communications like "come and eat", "go to sleep" etc. Also, during the period of chemical abuse, the person would have been continuously talking to his wife in the night, whereas in morning the wife would be continuously talking. In either case, there would have been no listener. Two-way communication would never have been there. Real issues like financial management, problems related to children etc, which had previously been ignored should now be discussed. Two-way communication is a **must** in the process of recovery. Addicts are likely to have feelings of guilt even during their recovery period. Therefore, in the beginning they may find it difficult to talk or communicate anything openly. It will help a lot if the family member takes the initiative and initially makes an effort to accept him and communicate with him. This will necessarily strengthen family relationships.

* When the addict abstains from drugs, there will be an increase in his appetite. He will like to have a variety of dishes. Formerly the wife would not have cooked properly. She should change this attitude and concentrate on his physical needs. She must take up the responsibility of making special dishes on occasions like festivals, birthdays, etc.

* So far, no importance would have been given to household cleanliness. The wife would have neglected her children, her house, and even herself. But now, she has got to change her old ways of thinking and behaving and take up her responsibilities and make her house a pleasant place to live.

* During recovery, the family may find it difficult to socialise. The family member would have been so isolated, that she would have even forgotten as to how to relate to others. It will help her if during the recovering period, she learns to get back into society, attend family functions and get togethers and communicate with friends and relatives. It will also help her if she attempts to pursue old hobbies which she would have enjoyed before the problem of addiction arose.

The following are a few guidelines which may help the family members to avoid facing problems during the recovery of the chemically dependent person:

* It is the responsibility of the chemically dependent person to stay away from drugs. The family member who had all along been protecting him, should make conscious efforts to refrain from taking responsibility for the consequences of his chemical abuse. Staying away from drugs and keeping sobriety intact is his own responsibility.

  To give an example, she should refrain from calling people and asking them not to serve liquor; she need not threaten 'old friends' saying, "He has taken treatment. If you force him to take drugs again, you will face dire consequences."

* All along the addict would have been treated only as a child and never as an adult. This is because he had never taken responsibility for anything, and would on many occasions have really behaved like a child. Now the family members should make conscious efforts to accept him as a responsible adult. Maturity automatically comes with taking up responsibilities. If he is gradually allowed to manage small problems, he will find himself competent enough to manage them. This will lead to his feeling of self-worth. They should stop providing help wherever he can manage all by himself. They should not protect him from facing minor problems.

* All along the family members would never have trusted the chemically dependent person. Now during his recovery, they should take extra efforts and learn to trust him gradually. They should build up and maintain a faith that he will be able to carry out his responsibilities.

* Normally the family members expect that after treatment the addict will totally change for the better. If this expectation is there, they will be disappointed. During the period of chemical dependency, he might have developed many personality defects like irresponsibility, dishonesty, and selfishness. Many of these defects are likely to continue during the initial stages of abstinence also. An awareness of this will make it easy for the family member to avoid impossible expectations. These defects will gradually change with professional counselling, with sharing and with exposure to AA.

* Even though the patient has undergone treatment, the family should not expect miracles to happen overnight. During the initial stages of recovery, he may have difficulty in concentration, thought process impairment and skill impairments. The family members should be aware of the problems he will be undergoing, and should be prepared to accept these and give him a helping hand. If this is done, he is likely to have a speedy recovery.

* The family members may experience a lingering fear all the time that the recovering person may have a relapse. They may find it very difficult to 'let go' their fear. As a result of this, they "take care" of the addict and try extra hard to retain peace and avoid conflict. This attitude of the family members should necessarily change. They should expect ups and downs during the recovery period, because real sobriety or full recovery may take years.

— **Not** attempt to punish, threaten, bribe, preach or use emotional appeal.

Punishment: "I will stop cooking if you continue drinking."

Bribe: "I will definitely clear all your debts if you stop smoking Ganja."

Threat: "If you don't stop taking brown sugar, I will commit suicide."

Preach: "Your liver will be damaged and you will end up in a hospital if you drink excessively like this."

Emotional appeal: "If you love me and your father, you will not smoke ganja again."

— **Not** feel guilty if the behaviour of the chemically dependent person is inappropriate.

Problems experienced by the family members during recovery

As chemical dependency develops into a family disease, virtually all the members of the family need some kind of help to recover. If chemical dependency has existed in the family over a long time, it is most likelv that all the members of the family will be in need of some outside help in restoring themselves to a state of health and happiness.

As already stated, in their efforts to protect themselves from the pain of the disease, they would have developed their own emotionally insufficient ways of coping with the problem. They would have already lost the battle.

If one member of the family makes efforts towards fundamental changes, it automatically creates a tendency in the other member to also change considerably.

Addiction is a disease that has taken years to develop and therefore cannot be resolved overnight, even with treatment. The family should be prepared for a long and conscious process of recovery. Rather than reacting with despair or defeat, the family members can help the addict to return to sobriety. Abstinence is the first step. During subsequent recovery, the family members must adjust to each other on a new basis in the course of which new problems may emerge. Roles and functions undertaken by the wife all along, would have probably provided some satisfaction. But some of these have to be necessarily given up.

Some problems experienced during chemical dependency may linger during the recovery period also. Lack of communication, unsatisfactory sexual relationship, mismanagement of finances, or difficulty in maintaining discipline can no longer be attributed to the stress caused by addiction or by the addicted individual. She should start "owning up" and accepting responsibility for some of the problems at home. Actually adjustment is initially difficult, but definitely possible.

— Try to accept the addict's relapses with calmness and understanding, because relapses are also a part of the disease.

— Accept the patient as a normal person and **involve him** in all the family activities.

— **Share** problems and feelings with someone you trust. This will help in ventilating negative emotions.

— Understand that addiction is a **progressive disease** which requires **professional treatment**. To do nothing about it, is the worst choice one can ever make.

In respect of some specific actions, you, as a family member SHOULD

— **Not** hide drugs or liquor. These methods will not work because the person will definitely know several ways of getting his supply of chemicals. As a result of this, you will only get frustrated.

— **Not** argue or quarrel with the person while he is under the influence of chemicals; asking him reasons as to why he drank or took chemicals does not help; he will only be justifying his action by giving excuses. These are not likely to be true at all.

— **Not** justify his use of chemicals. If you try to justify his use of chemicals, he will only continue taking drugs and not stop as you think.

— **Not** allow the addict to take advantage of your vulnerability.

Given below is an example of the alcoholic's manipulative behaviour.

> *Mithun was in need of money to buy alcohol; he chose the moment when there were visitors at home and demanded money from his wife. He did this, knowing that his wife would definitely give him money just to avoid an awkward situation.*

He was right. She did give him the money and he walked away to the bar.

If you give in, it will only lead to the perpetuation of the disease.

— **Not** take up the responsibility of covering up the consequences arising out of his inappropriate use of chemicals.

> *Kishore's father got a letter from his son's school stating that his academic performance was going down and that he was absenting himself for quite a number of days. The father who knew about his son's abuse of ganja, immediately went to the school and convinced the school authorities that his son was unwell and that was the reason behind his absenteeism and poor performance.*

This did not help at all because Kishore never realised his mistake. He knew that there was always somebody to take responsibility for the consequences of his action. He continued to take drugs.

— **Not** accept the promises given by the addict. Promises cannot be kept because he has a disease which requires treatment.

Even if there is a major crisis, her outward response will be minimal. Rewards for being apathetic are manifested in the feelings of self-pity and safety which she experiences. Actually she also seems to have developed an 'I don't care' attitude. While the apathetic person may appear to be calm, her behaviour does not quieten the anxiety she experiences within herself.

This behaviour is often indicated in ways such as:

— separating oneself from others
— passive rejection of the family
— wishful thinking and day dreaming

The family member who is apathetic allows the disease to progress. By refusing to recognise the problems associated with addiction, she helps to maintain the illusion that nothing is wrong with the family.

So far, we have dealt with in detail, the various behavioural responses and the different roles adopted by the family members. All these situations are a result of the family not being able to recognise the fact that addiction is a disease. The counsellor should appreciate the enormity of the problem experienced by the family and educate them towards implementing the desired behavioural changes.

Given below are some practical steps which will benefit the family immensely. The treatment professional could effectively use them in educating the family. To make it easy and convenient to use, the presentation is in direct narrative — as though the counsellor is actually talking to the family.

You, as a family member should

— Realise that addiction is a **disease** — not a moral weakness, not a lack of willpower, not a deliberate attempt at creating unpleasantness, not done intentionally or wantonly.
— **Accept** it. This will, to a large extent, help in changing your attitude and approach towards the person. Efforts can be initiated to show care, love and compassion. This in turn, is likely to speed up his recovery.
— This acceptance will have to get **'internalised'** steadily. Understanding or accepting merely at the logical level will not be adequate. It must take place at the level of **feelings and actions**. It may appear to be difficult initially, but it is achievable through continued efforts.
— Try to remain calm and patient. This tip may appear rather unrealistic. But this is not so. It can be achieved by adopting the following:
  a) plan for one day at a time
  b) never exaggerate or minimise the real consequences of any problem
— Realise that the disease of addiction has developed over a period of time. Recovery, therefore, cannot "happen" overnight.

To protect herself from further emotional pain and to hide her feelings, she takes on a protective defensive behaviour. At the **'JOHNSON INSTITUTE'** in Minnesota, they list out three generalised categories of defensive behaviour which an individual adopts in a stressful family situation:

— Being too good to be true
— Being rebellious and
— Being apathetic''

Being too good to be true is a defensive behaviour that is used to disguise the pain of the individual. It gives an illusion that the family does not have any problems. When she attempts to be too good, it is very apparent that she is looking for recognition in the family.

She keeps stretching her abilities to cope with the problems created by his abuse. She manages the house, looks after the children, makes all the decisions, counsels the addict and also earns for the family. She treats her husband like a child.

As she continues to do this, he starts thrusting more and more responsibilities on her. A period comes when the chemically dependent person starts finding fault with her if she does not properly manage any problem arising out of his inappropriate use of chemicals. She is expected to take up responsibility for everything, whereas he becomes less and less accountable for anything happening at home or outside.

As a result, this family member shows behavioural patterns such as:

— Struggling for an illusory perfection; denying any mistakes committed
— Acknowledging family stress only at the thinking level; denying feelings associated with stress
— Meeting everyone's expectations; trying to keep everyone happy.

While this behaviour pattern looks admirable, it insulates the chemically dependent person from having to experience harmful consequences arising out of his dependency. Performing all the duties which the chemically dependent person actually ought to be doing, only enables the addict to continue with his use of chemicals.

Being rebellious is another behaviour by which the family member diverts attention from the primary family problem of dependency. Most often this rebellious person draws negative attention — for example, when the addict shouts, she suddenly walks out of the house without any proper plans, and never bothers to inform anybody. She even calls the police and gets her son who is a ganja addict arrested. She hardly ever bothers to think about the consequences of these actions. ''Being rebellious'' is effective in disguising pain, because such behaviour brings the focus of family attention towards the rebellious person. Even though this is only negative attention, they adopt it.

Being apathetic is a defensive behaviour, which is very difficult to explain because the individual happens to be a passive person who shows no emotions whatsoever. The person quietly withdraws from stressful situations.

For example, the spouse may find the dependent person having lots of debts. Instead of making him realise and face the problems arising out of his irresponsibility, she clears all his debts and makes all his payments just to avoid an awkward situation.

In this process, she takes on the role of an ideal wife who is able to manage everything without any support. This, in turn, makes life easy for the chemically dependent person. He continues with his abuse. She continues to protect him, support him, apologise for his mistakes and find excuses for his drug abuse. She is not even aware that it is this role adopted by her that enables him to continue with his irresponsible behaviour and inappropriate use of chemicals.

Controller

The spouse makes all sorts of attempts to control the chemically dependent person's abuse. Some of the methods adopted by her are:

— asking him to drink at home
— pouring out liquor or hiding drugs
— accompanying him everywhere to control his accessibility to drugs

The more the spouse tries to control her husband, the less fruitful her efforts become. With a vengeance, he starts abusing chemicals more and more and the situation becomes worse.

Blamer

She desperately attempts to handle her increasing feelings of low self-esteem. Unknowingly her feelings of failure get projected onto others in the form of fear and anger. She instinctively feels that her husband is the reason behind all the family problems. She conceals her negative feelings about herself in typical ways.

Justification : "I unnecessarily beat the children, because I am unable to 'fix you'!"

Direct Attack : "If you are a **man** with a little bit of willpower, you would have stopped drinking long ago."

Sarcasm : "You are coming home at 10 O'clock at night. I am sure, your boss would have retained you at the office as usual."

Threat : "I will throw you out of the house if you don't stop taking brown sugar".

Loner

As chemical dependency progresses, the spouse/parent experiences inappropriate mood swings. She goes into deep depression and indulges in hours of lonely crying or violent outbursts of anger. These had been there earlier also, but now they are triggered by even minor provocations. Her uncontrollable mood swings make her feel that she is becoming insane.

Behavioural responses

The emotions described above lead to a set of behavioural responses to addiction.

The following are some of the instinctive but destructive behavioural patterns and roles adopted by the family members with the honest intention of helping the addict to get over his problem.

As fear increases, they experience a denial that is similar to the denial of the addict. Family denial normally takes two shapes.

Family denial*

1. The family denies the existence of any problem whatsoever and gives excuses such as "going through a stage" or "too much pressure", etc.
2. The family acknowledges the problem, but emphatically declares that the problem is limited to the dependent person. They believe that the chemically dependent person has been responsible for each and every problem in the family.

They not only deny that their actions, behaviour and attitudes have been affected, but also fail to see that the result is an environment that has lost its balance.

Denial is **different** from lying. It is an unconscious defence mechanism used without conscious knowledge or thought, to control fear and anxiety.

The family members are often as reluctant to give up familiar attitudes and behaviour, as the dependent person is to give up drugs. They share their fear of the unknown and that is the principal component of family denial. Fear accompanied by defence, serves as their survival technique.

Each family member becomes locked in a set of rigid survival defences and needs help to become aware of these compulsive behavioural patterns.

At this point in time, reality intrudes. As the disease of addiction progresses and becomes worse, the people who are significant to him realise that the problem can no longer be denied or hidden, and that they must do something about it. So they instinctively take on the following roles.

Protector

The spouse of the chemically dependent person is the primary 'enabler'* who starts with good intentions. She wants to show care and concern for the chemically dependent person and wants to get him out of his problems; apart from the above reasons, she wants to protect her own dignity. She takes on this role to bring down her feelings of guilt and low self-esteem. She covers up the consequences arising out of his inappropriate use of chemicals.

* Explained in detail in the chapter on "Denial".

Shame

Most of the painful experiences resulting from chemical dependency bring a lot of shame to the family members. The inappropriate behaviour of the addict in front of relatives and friends makes the family terribly embarrassed. As the situation in the family becomes worse, shame multiplies and the person starts feeling ashamed of the entire family — ashamed of the dependent and ashamed of all the other family members including herself. Shame produces low self-worth in each and every member of the family.

For example, the mother of an addict refrains from attending any social function because she is scared that people will ask about her son and his addiction. The very thought leads to shame and hatred.

Fear

Living in a problematic, distressed family produces fear — fear of the future, fear of family life, fear of financial matters, fear of relationships, fear of arguments, fear about the dependent's physical wellbeing, fear about his drunkenness and a persistent fear that nothing is going to become normal.

"What will happen to the family if things get worse?"

In fact, she is deeply afraid of everything. Even minor events cause her a lot of tension. For instance, if her child comes home five minutes late from school, she becomes terribly scared. But she does not bother to take any positive action that may alleviate her fear. These feelings of fear are the result of the internalised emotional stress which each individual family member experiences.

Loneliness

The stressful situation in the chemically dependent's family results in the breakdown of normal family communication. Love, care, and concern are lost in the stress, anxiety and crisis experienced on a day-to-day basis. The isolation created by lack of communication always leads to bitter loneliness.

To protect themselves from further emotional pain, they try to hide their emotions and do not disclose them to anyone outside. They begin to take on protective defensive behavioural patterns.

The family members talk a lot; but they never communicate with a purpose; they never share their feelings or emotions with each other. They also do not communicate with others around them. As a matter of fact, they are always **deeply alone**.

The addict gets angry and shouts throughout the night. The wife starts shouting at him the next morning. In either case, the other person does not listen at all. The most important fact is that the wife does not feel guilty any more for having shouted at him. As both of them shout at each other in turn, their anger seems to get 'evened out'.

Problems do not get resolved. Anger therefore does not subside. It continues to bubble.

Their anger gets misplaced; they shout at their children. Suppression of anger leads to physical problems like migraine headache, digestive disorders, etc.

With family members, anger is often the result of a mental conflict. Family members take care of the dependent person, but hate the painful experiences that they are forced to undergo. They become 'caretakers' with the only purpose of keeping their dignity intact and saving their own face. This caretaking attitude is not connected with any feeling of deep love at all. The painful experiences lead to anger towards the addict; and it is not at all easy to separate the dependency from the person. The wife feeds the alcoholic when he comes home totally drunk (caretaking). More often the same wife feels that he should die so that her life can be peaceful (hate).

Hurt

If anger is suppressed within a person, it automatically results in frustration, resentment and hurt feelings.

Emotional pain can be very deep and destructive. As the harmful dependency progresses, his inappropriate behaviour can no more be hidden. At every point, the family members feel humiliated. They are ashamed of the person, of his shameful behaviour, and they cannot do anything about it. It hurts to become involved in unnecessary arguments or witness angry exchanges. Normally the addict blames them for his shortcomings.

> *"I am not asking you to stay with me. I don't need you at all! You can go out of this house and get lost. I don't care!"*

Her immediate reaction will be

> *"I am not staying here for your sake. I am tolerating all these things only because I realise I have a duty towards my family and my children. If I had been as irresponsible as you, I would have left you long ago!"*

Even though she shouts, she is deeply hurt. This sort of deep emotional hurt adds to her feelings of guilt and shame. At times, she makes efforts to change her attitude and starts showing care and warmth. Even then she finds that none of her efforts lead to anything positive. The addict continues with his abuse and all the problems remain the same as before.

Such self blame produces more guilt and shame. Guilt of this proportion cannot be sustained or tolerated. Therefore in the course of time, each starts blaming the other, and this illusion prevents both the partners from developing self-awareness which might lead to a positive change. Each is trapped in his or her own net — the chemically dependent person in dependency, the spouse in the equally familiar and repetitive pattern of behaviour and attitude.

Grief

Grief is another emotional response of the family to addiction. The family has lost the pleasures of life. It is not a total loss that can be confirmed by death and mourning and a consequential healing. It is a chronic extended period of loss and anxiety with no visible end. There is the mere physical presence which neither helps nor supports. On the other hand, the presence itself creates unmanageable problems.

For the family members, grief is the result of all sorts of losses — loss of prestige, loss of family and personal dignity, loss of feelings of love, loss of care and understanding, loss of security, loss of friends, loss of finances — loss in each and every area of their life.

The most pathetic truth is that they do not share their feelings of grief with anyone. They suffer each and every problem all **alone**.

Just like any bereaved person, they need someone to listen to them as they pour out their grief; someone to understand that they are also victims of the disease; someone to help them to shift their feelings from the dependent person towards their own self. This is the only way which can help them overcome grief.

Anger

When they are not even heard, they experience anger and deep sadness. Initially this anger is focussed towards the addict and his inappropriate behaviour.

> *"Everyone is laughing at us. We are not able to go out at all — it is all because of you. Aren't you ashamed of yourself? I wish you were dead!"*

As the disease worsens, the wife or parents are unable to manage the enormous problems any more. They do not know what to do. Their utter helplessness makes them get more angry. Now their anger does not have any focus at all. They are angry with themselves, with their husband even when he is not drinking, with their children, friends, society — in short, their anger is directed towards the entire world at large.

Even though the family members are extremely angry, they never let off steam. Hostility lurks just below the surface, waiting for an opportunity to come out in the open. Anger sometimes explodes, but the family member is not able to achieve anything positive.

Codependency means being a partner in dependency. "Codependency is an emotional, psychological, and behavioural condition that develops as a result of an individual's prolonged exposure to, and practice of, a set of oppressive rules — rules which prevent the open expression of feelings as well as the direct discussion of personal and interpersonal problems." (Robert Subby). "Codependency" is the term used to describe a person whose life is affected, as a result of her involvement with the chemically dependent person. This codependent normally develops an unhealthy pattern of coping with life. Even though she wants the addict to give up drugs totally, she unconsciously takes up defective and destructive roles which strengthen his chemical dependency.

Codependents are people who keep on **reacting**. They react to the problems, pains, and behaviour of others. They react to their own problems and pains. They will have to be guided to **act** rather than to react. They need a great deal of help to learn to **act**.

As the problems around mount up, codependency leads to isolation, depression, emotional/physical illness and suicidal attempts. Like any other repetitive behaviour, it becomes habitual. Codependents keep repeating habits without thinking; and these habits automatically take on a life of their own.

Let us now analyse the various responses and behavioural patterns of codependents.

Emotional responses

When a chemically dependent person gets into trouble and develops problems due to the abuse of chemicals, his family is deeply concerned and gets upset.

Guilt

The emotional response to addictive illness in a family member frequently has its roots in guilt feelings. Our culture often implies that if a person drinks too much, or takes to addictive drugs, someone else is to be blamed.

Normally, the outside world blames the wife or parents.

> *"Ram's wife is from a very rich family. She is arrogant and always tries to boss over him. She does not care for him at all. No wonder Ram drinks a lot."*
>
> *"I have never seen parents like these. They are very indulgent. They never cared for their son. They put him in a hostel. Poor boy! That is why he is on drugs!"*

Society's attitude and outlook automatically lead to self-blame.

> *"Am I responsible for his drinking?"*
>
> *"Am I inadequate?"*
>
> *"Does he deserve a better wife?"*

10
PROBLEMS EXPERIENCED BY THE FAMILY

Chemical dependency is not an isolated effect that affects only one individual. For every case, there are multiple victims. Apart from the chemically dependent person, the prime victims are his wife, parents and children.

Each family seems unique. Yet all of them have certain common traits and characteristics. All families tend to react in patterned and predictable ways when one member of the family becomes the victim of chemical dependency.

The working of the family is directly related to and influenced by the sickness of the chemically dependent person. The members of any family operate in a system, wherein they are interdependent and work together for survival and enjoyment. When there is stress, the whole family readjusts and realigns itself in order to bring about balance and stability.

The family of the chemically dependent person is a set of hurt, confused people. They are victims of addiction who do not use chemicals, but are nevertheless victimised by the drug. They are victims struggling desperately to solve their problems.

"The chemically dependent partner numbs his feelings, and the non-abuser is doubled over in pain — relieved only by anger and occasional fantasies", wrote Janet Geringer Woititz.

The family members of the chemically dependent person suffer in the background of the sick person. These people are rarely treated as individuals who need help. They are rarely given a personalised recovery programme for their problems and pain. The pathetic truth is that they are also desperately in need of proper help, support and understanding.

These people who do not drink or take drugs but are victimised by chemical abuse, are called **codependents**. Codependency is a normal reaction to the abnormal behaviour of people around.

Chemical dependency means being physically and psychologically dependent on alcohol or other drugs.

★ Parents should learn to respect the feelings of their children. Often feelings are expressed less directly but with enough cues so that a sensitive receiver can pick them up. The child should be given a feedback that he is being listened to.

★ Since children tend to adopt the behaviour and values of the parents it is very important that parents always do what they expect their children to do. The chances of children taking to drugs are more, if the parents themselves drink alcohol or smoke heavily.

Parents may ask the counsellors as to how they can find out if their children are addicted to chemicals. Counsellors should educate parents regarding the changes (physical and others) that indicate the use of chemicals. The following are the indicators:

Recognising a chemically dependent child

Physical changes

-- Reddening of eyes due to smoking cannabis
— Vacant look at times
— Puffiness under the eyes
— Slurred and unclear speech
— Unsteady movement
— Poor eating habits
— Poor hygiene
— A number of injected sites on the body

Other changes

— Poor attendance at school/college
— Sharp decline in academic performance
— Highly irritable
— Happy for sometime and angry the very next moment.
— Peculiar smell on breath and clothing
— Presence of candles, bent blackened spoon, silver foil, strange packets etc. at home
— Spending long hours in the toilet
— Disappearance of articles from home

A point to be emphasised is that these changes should be seen repeatedly and over a period of time. Parents should avoid coming to hasty conclusions based on wrong judgement.

What should the parents do?

When a parent identifies that his child is an addict what are the immediate steps to be taken?

The first step a parent should take is to **ensure** that his son **is definitely** taking drugs. This can be done by checking with the teacher about his attendance and performance. It can also be done by talking to his friends and sharing a sense of concern about possible unusual behaviour, apparent mood swings, money borrowed, etc.

If the fact is established, the parents would normally get terribly shocked, angry and would immediately feel like punishing the child. The counsellor should tell the parents that they would have to control these emotions and try to be:

★ Understanding

"I am not blaming or comdemning you. I understand you have a problem and that you need help."

★ Firm and supportive

"This has affected your studies and health drastically. This cannot be continued. You have to take treatment. All of us are here to help you in every possible way."

What should the parents not do?

— **DO NOT** talk harshly

"You have always been giving me trouble. You never allow me to live in peace."

— **DO NOT** tell the child that he is cheating

"All the while, we believed that you were studying. Your mother and I have been working hard only to provide you with good education. But you have cheated us thoroughly."

— **DO NOT** indulge in self-pity

"Why should this happen only to me? Why should I alone suffer so much, at this age, when everyone else is relaxed and contented?"

— **DO NOT** blame yourself

"My sister warned me not to allow you to stay in the hostel. But I did not listen to her advice. It is my fault.... only my fault."

Parents should be made aware that if they do not adhere strictly to the above, their child will not accept help from them. This will make the problem more complex.

With the drug problem assuming such magnitude, prevention is largely in the hands of the parents. A good parent – child relationship goes a long way in the prevention of drug abuse.

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13
TREATMENT

The disease of addiction affects the 'whole' person - physically, mentally and psychologically. Therefore, therapy for the addict should also address man in his totality.

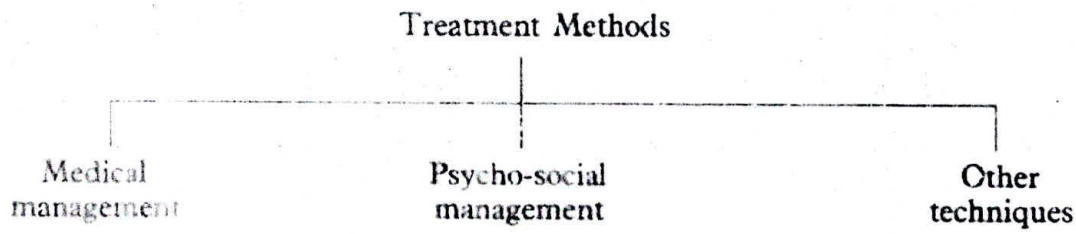
Addiction-treatment is not the responsibility of a single profession. People from various disciplines work together in the common task of treating and rehabilitating the addict. Doctors, nurses, psychologists, social workers and recovered addicts are the members of the therapeutic team, who have to work together in co-operation, to achieve the best possible results.

Goals of treatment

In most of the treatment centres, the goal is, **complete abstinence from drugs,** in any form and under any condition, for the rest of the patient's life. This is coupled with the goal of a change in life style, which will help in arresting the disease. Currently, research is being conducted to determine if a return to social drinking might be possible for some individuals. However, this is a highly debated and controversial issue and no definite conclusions have been drawn so far.

Methods

Various methods, in different fields, have been implemented by various professionals. These are discussed below:



Medical management

Medical management becomes necessary to handle problems associated with drug abuse. Medical help is given in the following ways:

- handling problems associated with overdose of drugs
- dealing with withdrawal symptoms
- administering medicines like antabuse or narcotic antagonists

Overdosage

Overdosage is the intake of chemicals in a quantity larger than that normally or safely taken at one time. This usually leads to some adverse or toxic reactions, which can even be fatal. Frequently, overdosage or excessive consumption occurs in drugs like opiates, hypnotic-sedatives or alcohol. These depress the central nervous system, and result in pneumonia or heart failure. Prompt and careful medical attention becomes essential.

Withdrawal/Detoxification

Withdrawal results from physical dependence. The problems which arise after sudden cessation of drugs leads to withdrawal symptoms, and the treatment of this is known as the detoxification process. Severity of withdrawal and the symptoms depend on many factors, including type of the drug, extent of addiction, prior history of head injury, poor nutrition, or fluid and electrolyte imbalance.

Detoxification is the medical management process used to remove the toxicity of the drug from the body and ensure that the patient undergoes safe withdrawal from chemicals. Necessary medical care for treatment of acute and chronic medical problems associated with addiction, are also given.

This process normally takes about 3 - 10 days, but may vary in individual cases.

Administering medicines

Disulfiram (Antabuse)

Disulfiram is extensively used in the treatment of alcohol dependence. If alcohol is consumed along with (prior to or after) disulfiram, it produces unpleasant effects. Disulfiram interferes with the metabolism of alcohol, and produces flushing, sweating, palpitation, tachycardia, shortness of breath, discomfort in the chest, vertigo and blurred vision. Even small amounts of alcohol such as those present in cough syrups can precipitate a reaction. These adverse reactions serve as a deterrent to the alcoholics.

Disulfiram is considerably useful for the patient who wants to achieve abstinence. It helps the patient to overcome momentary crises like peer pressure to resume drinking, unexpected stress, overwhelming anxiety, or an 'acute craving'.

Prolonged use of disulfiram produces side effects like metallic taste in the mouth, interference with the metabolism of certain drugs, insomnia, generalised weakness, fatigue, and impotence. In rare cases, it induces psychosis. Most recently, there have been experimental attempts at producing disulfiram implantation which may be effective for several months.

Narcotic Antagonists

These drugs block the pharmacological action of the narcotic drugs. If the person taking narcotic antagonists, uses narcotic drugs (heroin, opium etc), the usual euphoric effect induced by the narcotic drug is not felt. Therefore, the positive reinforcement for the use of narcotics is cut off, and this helps in abstinence. Besides this, he will also experience withdrawal symptoms. These narcotic antagonists are, as of date, not produced in India.

Psychosocial management

Psychosocial management consists of different methods of psychological treatment procedures. These include:

- individual counselling
- group therapy
- family therapy
- behavioural therapy

Individual counselling

Individual counselling is the technique which involves insight, persuasion, suggestion, reassurance, and instruction, so that the patients may see themselves and their problems more realistically and develop the desire to find methods to cope with them.

Individual counselling has to be given on a long-term basis. This helps the patient to maintain abstinence. Intensive counselling can be given only if the patient has either been detoxified or has not taken any chemicals. Counselling has to be supported by other forms of treatment methods like group therapy, family therapy, relaxation techniques, etc.

Individual counselling skills are discussed in detail in Chapter 18.

Group therapy

Group therapy has been used over the last few decades. Group therapy is the technique of treating patients in groups. This technique emphasises the fact that the patient's problems are not unique. It makes available the acumen and experience of chemically dependent peers, who do sometimesspot denial and confront the patient. Hindered by negative attitude towards authority figures, addicts often accept confrontation by other patients rather than by the counsellor.

Group therapy skills are discussed in detail in Chapter 24.

Family therapy

Family therapy can be defined as the treatment of more than one member of a family simultaneously in the session. The treatment may be supportive, directive or interpretive. The problem experienced by one member of a family may lead to disturbances in the other family members and may affect interpersonal relationships and functioning.

While treating the chemically dependent, the entire family is brought together to discuss problems — problems of communication, role clarity, developing trust, dealing with past resentment, etc. Helping the family members improve their interactions not only serves to improve family functioning but also helps the chemically dependent person in maintaining abstinence.

Carefully utilised family therapy, along with the specific treatment for chemical dependency, can lead to long-term abstinence and a marked improvement in the family situation.

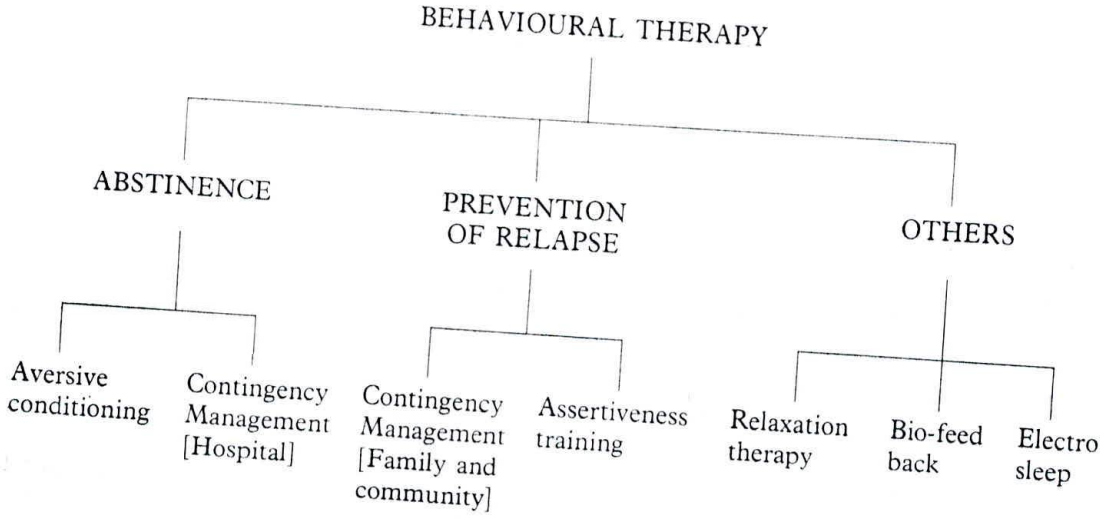
Behavioural therapy

Behavioural therapy is the systematic application of "learning principles and techniques" in the treatment of behaviour disorders. The therapy focusses on attacking the symptoms rather than on tracing the cause of the problem. Change is brought about by conditioning or other learning techniques. The commonly used conditioning principle in behavioural therapy is operant conditioning, where desired alternative responses are elicited by rewarding them.

Behavioural treatment of addiction is based on operant conditioning coupled with social learning concepts. In this framework, excessive use of chemicals is seen as a behaviour that is under the control of antecedent stimuli and consequent events (reinforcers). For example, an individual has an argument with his wife, feels tense, and therefore drinks alcohol. He feels relaxed and light after consuming alcohol. This acts as a reinforcer for him to consume alcohol. This acts as a reinforcer for him to consume alcohol, whenever he feels tense, or faces a stress. Thus the task of therapy is to modify or manage various environmental events to engender abstinence, and to improve social functioning.

This section reviews some of the recent developments in the behavioural treatment of chemical dependency. Three groups of techniques are differentiated:

1. techniques for abstinence
2. techniques for prevention of relapse
3. other techniques to help the patient improve overall functioning.



Techniques for abstinence

Aversive conditioning

Punishment for drinking behaviour and the pairing of sights, smell and tastes associated with drinking with aversive stimuli is the core of this method. Usually, electric sub-shocks are given to the patient when he sips alcohol. These dermal shocks are painful and are thus associated with sips of alcohol. The shock can be terminated by spitting out the alcohol.

In another technique, the patient is induced to imagine uncomfortable or adverse experiences or perceptions (such as vomitus, nausea) in association with thoughts about drinking/drug taking or pubs/bars or taste of chemicals. Here physically painful stimuli are not used.

Inducing disulfiram reaction in a patient is another type of aversive conditioning. This is known as the 'challenge test'. The patient is made to consume alcohol while on antabuse, so that he can experience the noxious reaction. This is done under close medical supervision.

Contingency management in a hospital setting

A variety of innovative therapeutic interventions are based on operant conditioning principles. Here reward is contingent upon occurrence of desirable behaviour. Reward can be in many forms — financial, emotional or social. Thus if the patient does not consume chemicals in the hospital, attends group sessions, and is regular for appointments etc (desirable behaviour) he can get free passes to go out for walks, use the telephone or get food from the canteen.

Techniques for prevention of relapse

Contingency management in the community and family

This technique is based on social learning theory, and contains some separate components designed to provide satisfaction that will continue to prevent/postpone drug taking:

1. Placement in a steady and remunerative employment.
2. Marital and family counselling to increase participation and derive pleasure from family activities.
3. Social clubs to provide support for abstinence during free time, and
4. Enhancement of activities such as hobbies and formal recreation to provide alternatives to chemical abuse.

Assertiveness training

Assertiveness training helps people overcome anxieties and inhibitions. It aids in the development of greater interpersonal skills and more effective and spontaneous social behaviour.

Assertiveness is an essential trait to be developed by the recovering patient, and this plays a crucial role in both recovery and relapse prevention. This has been discussed in detail in Chapter 26.

Other behavioural therapy techniques

Relaxation therapy

Relaxation therapy is a form of behavioural therapy wherein the patient is taught to relax by demonstration of the opposing feelings of tension and relaxation. Many chemically dependent individuals have difficulty relaxing during the early phase of abstinence. They experience muscle tension, feelings of dysphoria and anxiety. Relaxation helps them alleviate insomnia and other psychophysiological disorders. This has been discussed at length in chapter 25.

Biofeedback

Biofeedback focusses primarily on the direct modification of physiological responses as opposed to cognitive or motoric responses. The eventual goal of these techniques is to prevent or reduce the occursence of the unpleasant/negative physiological responses. Biofeedback in treatment of chemical dependency is used to teach the patient to bring about a relaxation response. In this method some means — such as alpha waves from the electro encephalograph (EEG) or Galvanic Skin Response (GSR) indicating perspiration — are used to provide the individual with some perceptible "feedback" regarding the state of their body or brain waves. Since alpha waves or a low GSR are associated with a state of relaxation, the individual is asked to relax.

Once a low GSR or alpha waves are produced, a perceptible 'feed back' stimulus (such as a sound with specific tone) is produced. As the individual becomes less relaxed, the sound or tone changes. Thus the patient 'learns' to get into a state of relaxation.

Electrosleep

In this method low voltage electrical current is passed through the head (not high voltage as used in ECT's). It produces a state of relaxation, accompanied by a sense of wellbeing or euphoria. It has been used to treat mild to moderate withdrawal symptoms.

Other techniques

Acupuncture

In recent years, patients have received this treatment. This method is more popular in Asia. It has been applied for the acute phases of narcotic withdrawal. A wide variety of acupuncture methods have been applied. Some of them consist only of placement of needles without electrical current. Other approaches include placement of needless in the ear or earlobes, followed by the passage of a low voltage current across the head. Acupuncture technique can alleviate the agitation and pain of withdrawal and produce rapid sedative and even euphoric effects on the patient.

However, tachycardia (increased heart rate), hyperventilation, and perspiration continue despite the other clinical changes evident in the patient.

Comprehensive multi-disciplinary approach

A **comprehensive** treatment programme, implemented by a **multi-disciplinary team** has been found to be most beneficial. We have discussed below in detail, the various treatment facilities available in other parts of the world.

There are four broadly described phases in the treatment of addiction:

- Identification/intervention
- Detoxification
- Rehabilitation
- After-care

Identification/Intervention

Identifying a chemically dependent person and motivating him to take treatment are often carried out by a relative, a friend, a fellow employee, a supervisor, a doctor or by school authorities. When the chemically dependent's wife or parent brings the person for treatment, it is called family intervention. Similarly, there may be medical intervention, where the physician intervenes, discovers certain physical damages in the individual indicative of drug abuse and refers him for treatment.

There can also be occupational intervention, in which case, the employer identifies the addict through an Employee Assistance Programme or by mere observation and reports from the fellow workers. It can also happen due to the intervention of school authorities who inform the parents about the possible drug problems the student may be going through.

Information, assessment and referral services

After identification, they are brought to assessment centres. These organisations are located in industries providing EAP programme, welfare agencies, and schools. In these centres relevant information including the history of chemical use is collected from the patient and from other sources. Based on this information, chemical dependency and other related problems are diagnosed and referrals suggested.

Detoxification

Detoxification is a process wherein the toxicity of the drug in the body is removed.

This calls for an inpatient setting, with close medical supervision.

Detoxification Centres

The primary function of these institutions is to provide treatment services for detoxification of patients who are experiencing withdrawal.

Detoxification centres are located in hospitals, emergency care services, etc.

The staff include physicians, nurses and counsellors. Here the patients undergo detoxification for a period of 3 to 10 days. This period varies depending on the condition of each patient.

These centres provide counselling units which motivate the patients to take further treatment. Referral to appropriate treatment programme for continued care is also made.

Rehabilitation

This phase aims at helping the addict work towards abstinence, and making him realise that he can also be useful to and respected by his family, friends and community. It also helps the patient to make positive changes in his life style.

During this phase, the family of the addict is also given intensive therapy. The programme helps the family and friends understand that addiction is a disease, become aware of treatment and post-treatment experiences and the need for making improvement in their lives. This service is provided in different settings. These include:

- Residential treatment facility
- Therapeutic community
- Out-patient programme

Residential treatment facility

These treatment centres provide an intensive structured programme of treatment and rehabilitation wherein patients are given individual attention. These are done in in-patient settings. The goals of this treatment are:

— to help the addict give up drugs totally for life
— to bring about positive changes in the patient's behaviour and attitude, and thereby enable him to lead a qualitative life.

The treatment methods adopted are individual counselling, group therapy, recreation therapy, therapeutic community meetings, and relaxation techniques. The philosophy of AA (i.e., powerlessness over alcohol and belief in a Higher Power) plays a significant role in the treatment programme.

The interaction between individuals and the group is utilised to reinforce and strengthen continued abstinence. Balanced diet and supplementary nutrition are provided as part of this therapy. Patients are involved in therapeutic activities like cleaning the room, helping in the kitchen, watering the plants in the treatment centre, etc. On completion of the programme the patient will be presented with a medal in a small farewell party.

Counsellors specialised in the treatment of addiction and recovered chemical dependents play a major role in providing counselling services. These recovered addicts help the patients to get the maximum benefit by combining their personal experience of recovery with specific training.

Therapeutic Community

This is a residential treatment programme based on therapeutic community principle that has evolved from psychiatric setting over the last few decades. The objective here is the establishment of a therapeutic social milieu. Programmes usually include frequent community meetings and group therapy sessions. In these groups, peer pressure is used to bring about change in patients and also to confront individuals whenever necessary. Behaviour modification techniques are also employed to modify undesirable behaviour. There is usually little or no use of pharmocological treatments, individual psychotherapy or marital therapy.

This programme seeks to achieve a major behavioural and psychological reorientation of the individual. Much of their work involves complete resocialisation of the individual, as part of their rehabilitation.

In order to benefit from therapeutic communities, patients may be required to stay for long periods.

Out-patient programme

This is designed for the ambulatory patient to receive medical/rehabilitation care from a hospital or a clinic. The primary function of the institution is to provide treatment in a non-residential setting. These patients do not require in-patient care,

but need specialised treatment to come out of their chemical dependency and to make adjustments to the problems they are likely to face during abstinence. Counsellors prepare a social/psychological assessment of each patient and assign him to group counselling sessions that meet regularly — evening or night sessions for those who are employed and day sessions for those unemployed. Individual counselling is also included as part of the out-patient therapy programme. If a patient is found to be drinking or taking drugs while attending the programme, he is transferred to the in-patient programme, or if he is found to be difficult (uncooperative, irregular, arriving intoxicated), he is discharged.

After-care

This includes the package of services provided to the patient after successful discharge from the programme. After-care activities can be viewed as the first line of defense against return to drug use. The activities include attending self-help programmes like NA/AA, regular follow-up at the treatment centre, staying at the half-way home, etc.

Self-help groups

Self-help groups are voluntary, small group structures formed for mutual aid and for the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need — which may be overcoming a common handicap or a life-disrupting problem or bringing about a desired social and/or personal change, — through emotional support.

The most well known self-help groups associated with chemical dependency are:

1. Alcoholics Anonymous for alcohol dependent patients (AA)
2. Narcotics Anonymous for drug dependent patients (NA)
3. Al-Anon for spouses or relatives of addicts
4. Al-Ateen for teenage children of addicts

These are discussed in detail in Chapter 15.

Half-way homes

This is a programme that attempts to combine the advantages of the residential treatment with those of the ambulatory treatment. Patients live in a group, but are permitted to leave the premises during the day and on week-ends. Problems are solved through group interactions and community involvement. Members of this programme would have already gone through a primary treatment.

The primary function of the institution is to provide, on a residential basis, support and guidance to the patient to proceed towards the goal of independent living. These patients require limited medical supervision but are in need of continued help to tackle their alcohol/drug related problems. These centres provide supportive help in the form of occupational, social and recreational activities.

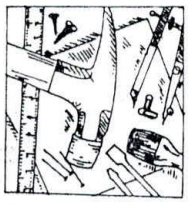
Patients who do not have a family or who are unmarried or divorced, or those prone for relapse are recommended for this programme.

The treatment of chemical dependency involves considerable skill, patience, understanding and experience. There is no known cure for chemical dependency. The disease can only be arrested, and the chemical dependents are given guidelines to lead a healthy and productive life without chemicals.

Value additions place

— Additional information

Phase	Goals	Methods	Settings
Phase I Identification/Intervention	* Problem definition * Patients entering treatment	* Breaking of denial through empathetic, non-judgemental, supportive, confrontation * Individual therapy	Referral agency, Employee Assistance Programme, School Welfare Agency, Physician's Office, Criminal Justice System, In-patient or out-patient medical and psychiatric services
Phase II Detoxification	* Helping the patient to become drug free * Motivation counselling towards treatment and rehabilitation	* Ingestion of medicines * Nursing care * Counselling	Out-patient emergency care services, in-patient hospital or detox services.
Phase III Rehabilitation	□ For the patient and his family * Change in self concept * Change in personality traits * Change in life style * Restoration of physical health with proper nutrition	* Individual counselling * Re-educative lectures * Group therapy * Relaxation therapy * Spiritual counselling	In-patient, Out-patient, Day programme
Phase IV After-care	* Prevention of relapses * Reinforcement of new patterns of sober living	* Same as Phase III * Self-help groups * After-care sessions * Vocational rehabilitation	Out-patient clinics Half-way homes



— Implementation tool

A 'model' treatment programme

TTK Hospital/T T Ranganathan Clinical Research Foundation is a secular, non-profit, voluntary, welfare organisation, dedicated to the treatment and rehabilitation of persons addicted to alcohol and drugs.

A comprehensive treatment facility covering both medical and psychological help is provided by the hospital in the treatment of alcoholism and drug addiction.

Treatment at the TTK Hospital aims at:

★ total abstinence from alcohol and drugs for life
★ effecting positive changes in the behaviour and attitude of the individual to enhance the quality of his life.

The treatment programme has been drawn up to offer the patient medical help and psychological support that will enable him to recover from the disease of addiction. Family members are also educated about the disease and are provided guidelines to improve the quality of their life.

The in-patient treatment programme at the TTK Hospital is a residential, multi-disciplinary therapeutic programme, conducted by a professional team of psychiatrists, physicians, psychologists, social workers, resident counsellors and nursing staff. The duration of the treatment programme is 4 to 6 weeks.

Incoming patients are directly admitted to the detoxification centre where the required medical treatment is given. Withdrawal symptoms due to sudden stoppage of drug usage, instances of acute intoxication and chronic health problems associated with addiction are dealt with during detoxification.

When the physical condition of the patient stabilises, he is transferred to the psychological therapy wing.

The psychological therapy is also run as an in-patient programme. The patients have a three week programme, each day structured with activities which include community meetings, lecture classes, group therapy sessions, individual counselling sessions, relaxation therapy, recreation and AA/NA meetings.

Since chemical dependency is a disease that affects the patient as well as his family members, they are also given psychological support and treatment.

The family programme is for two weeks and they also have a structured daily schedule including community meetings, lecture classes, group therapy, counselling, relaxation therapy, Al-Anon meetings. The children of addicts are also given support during this phase.

The topics included for the re-educative lecture sessions for patients are:

1. Drugs and their effects
2. Addiction — A disease
3. Denial
4. Emotional cost of dependency
5. Dry drunk behaviour
6. Problems in recovery
7. Sober living
8. Values
9. Self-esteem
10. Anger
11. Effective communication
12. Sex education
13. Coping with stress

Some of the topics discussed in group therapy are:

1. Damages — physical, social, family, financial and educational
2. The worst drug taking episode
3. Blackouts and accidents
4. Grandiose behaviour

5. Loss of control
6. Insane and destructive behaviour
7. Preoccupation with drug taking
8. Powerlessness
9. Unsuccessful attempts to give up drugs
10. Denial
11. Violation of values
12. Problems in sobriety
13. Methods to remain sober

The re-educative lectures for the family include:

1. Addiction — a disease
2. Roles taken up by family of addicts
3. Self-esteem
4. Understanding values
5. Effective communication
6. Problems in recovery
7. Children of addicts
8. Coping with anger

After the completion of this programme the patient is discharged and is encouraged to attend after-care programmes.

After-care

After care programmes at the TTK Hospital offer a package of services for a period of 5 years following discharge. They include follow-up counselling sessions, meeting the doctor, and attending AA meetings. After-care is usually done on an out-patient basis, since the focus is on personal re-entry into the community and coping with the immediate problems associated with abstinence and recovery.

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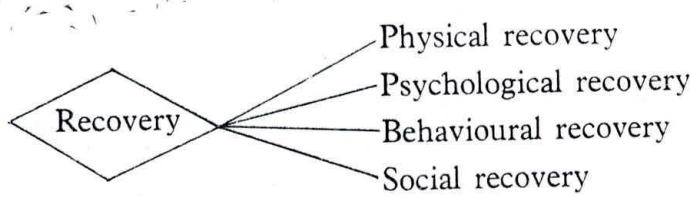
14
RECOVERY

For a chemically dependent person, recovery starts with abstaining from drinks, or drugs. This abstinence should be total and for life. In addition, it should be combined with a healthy adjustment of thoughts and feelings towards achieving balance and harmony with the living environment. Recovery denotes an orderly arrangement of the significant aspects of life.



Recovery means learning to manage life better; it means learning to cope effectively with financial problems; it means leading a 'qualitative' life.

It is therefore important that the recovering addict works out a daily structured programme and executes it. He should have an effective programme which provides guidelines for "effective thinking, reasoning, problem solving, regulating emotional reactions, and structuring time and daily activities".

As part of a structured plan the chemically dependent person goes through clearly defined, distinct phases of recovery. Each phase of recovery demands a specific plan of action. Incompleteness of treatment in any phase — early, middle or late — will automatically lead to a relapse.

Pre-treatment problems

In the period prior to the patient reporting for professional help, the chemically dependent person was not required to face any crisis arising out of his improper use of chemicals all by himself. His employer, wife, parents or somebody close to him, was always there to cover up the consequences and assume responsibility for the problems created by his addiction.

This enabled him to continue taking drugs or drinks. Once the employer, family members or friends stopped covering up the consequences of his abuse of chemicals, he was forced to face his chemical-related problems squarely — all by himself. He could not manage the crisis. He "hit the bottom". Following such a 'motivational crisis' he sought help.

At this stage, people significant to him encouraged him to take treatment. They intervened, and motivated him to seek help. Normally the people who intervene are his employer (Occupational intervention), the family (Family intervention), or the physican (Medical intervention).

Stabilisation (starting point of recovery)

This period starts with detoxification. It is followed by motivational counselling. During this period, the patient gets gradually stabilised physically and psychologically, so that he recognises the crisis and its origin — namely his abuse of chemicals. He has to get completely stabilised neurologically and psychologically. Physical well-being experienced due to detoxification may make him feel that he is normal, and he may start thinking that he can attempt controlled drinking/drug use.

The patient at this stage, would not have acquired sufficient knowledge about the disease to make decisions all by himself. He needs direction.

He may be confused and will be looking for answers. If he does not receive information and guidance immediately, he will begin to create his own answers. In most cases, these answers are likely to be part of his original denial system. He may re-establish and fixate upon his own rationalisation.

Stabilisation begins not merely with the process of giving adequate information to the patient. It actually begins with the **attitude of the therapist**.

The counsellor should provide positive support, reassurance, and encouragement. The patient should not feel that he is being judged or condemned. As he comes to realise that there are non-judgemental people, who are prepared to accept and believe him, he will automatically start believing himself.

He should be encouraged to express his feelings. Even if he looks panicky and confused, he will begin to take steps to stabilise himself. He will gradually come to realise that his thinking all along, has not been consistent with reality.

Apart from the patient, the family and the concerned people will also be upset, frightened, hurt and angry. So his family should also be part of the treatment and recovery process. They should also be stabilised along with the patient.

Early recovery

As soon as the initial stabilisation is achieved, an intensive diagnostic presentation should be made, and the patient should be given all information about the disease of chemical dependency and he should also be informed about the related problems that are likely to persist even during recovery. If the family or employer intervention had taken place earlier following a crisis, those events should be narrated to him, repeatedly if required, during this period. This is because the chemically dependent person is likely to have memory impairments and would by now have forgotten what happened earlier. So, narrating these incidents again would help him to recall them and become aware of the entire background with a certain degree of clarity.

Middle recovery

The powerful impact of the diagnostic presentation made during the early recovery period should motivate him to decide without any hesitation to recover fully. It should give him the conviction that his abnormal use of chemicals is the root cause of all his problems.

By now, the patient should feel convinced that **treatment is absolutely necessary** and that it is also possible to recover fully. He can foresee and emotionally accept the problems he is likely to face during recovery. The conflict between his mind and emotions might have been resolved. He will be convinced that recovery is worth the price. At this stage, he should be able to formulate a structured life plan all by himself.

Unfortunately, many patients enter this phase of treatment without completing the task of stabilisation and pre-treatment periods. As a result, they are unable to cope with the demands of the middle recovery period. Even if they try hard, they will definitely fail. They fail, not so much because they do not want to recover, but more due to the fact that they have not been prepared to enter this phase of recovery.

At this juncture, most of the counsellors blame the patient for his failure and confront him in a non-supportive manner. As a result, in spite of the best of intentions, treatment becomes unproductive. This sort of confrontation will either strengthen the patient's denial mechanism or make him merely comply without undergoing any change in perception or attitude.

Late recovery

During this period, the problems related to chemical abuse are identified, as distinct from other life problems which are not related to chemical dependency. He would also have developed a functionally independent personality which would enable him to manage his problems better. He should also re-establish his spiritual values. His attention should be drawn strongly towards a qualitative life.

Maintenance period

Chemical dependency is a chronic disease. The most important aspect of this disease is that it creates a tendency in the chemically dependent person to go back to his old way of life, and the desire to use chemicals to rationalise or escape from problems. Some of the aspects of this disease continue during the recovery period also. Sobriety can be maintained only if the patient recognises the need to stay away from chemicals for life and make a structured daily programme and turn it into action. Failure to meet these needs will definitely lead to a relapse.

The counsellor must help each individual to prepare a structured plan based on his needs. He should also be motivated to seek AA/NA for help and he should be informed about the absolute necessity of constant follow up with the counsellor.

Chemical dependency "is a life long disease..... As a result of lack of treatment resources designed to meet the need of early and late recovery, many patients relapse in spite of their honest efforts at maintaining sobriety. In spite of their best efforts to help their patients, many treatment professionals fail, not because they are incompetent, but simply because they are unaware of the long term developmental process of recovery."*

Factors that complicate recovery

There are conditions and situations that complicate the normal recovery process. Patients experiencing complications should be given specialised treatment, appropriate to their particular complication.

If a patient does not respond to treatment, a detailed evaluation should be immediately done to identify any possible complication that may be interfering with his ability to recover. Some of the frequently found complications are dealt with below:

Severe problems experienced during abstinence

Acute withdrawal syndrome (AWS)

Recovery begins with removing the chemical from the body. During this period, AWS can manifest itself in two ways.

1. It is evident by the agitation of the central nervous system and shows itself in the form of tremors, hallucinosis, delirium or convulsive seizures.
2. There is internal anguish and internal agitation. There is an increase in physical stress, elevation in blood pressure, pulse and respiration. Progressive discomforts and fear of behavioural loss of control will begin to manifest themselves.

* Reproduced from Terence T. Gorski and Merlene Miller, Counselling for Relapse Prevention, Herald House, Independent Press, U.S.A. 1982.

The patient should be observed very carefully when he experiences either type of AWS. In most cases, both medical and behavioural management become necessary. The medication given should be addressed to the need to prevent the body from over-reacting to the stress of being without the chemical.

Behavioural management consists of individual attention, talking about his pain and anxiety, stress management exercises and reassurance.

Post acute withdrawal syndrome (PAW)

The major symptoms* of a post acute withdrawal syndrome are thought process impairments, emotional process impairment, short term memory impairment, stress sensitivity and over-reaction to stress.

Normally the symptoms of 'post acute withdrawal' subside over a period of six months to two years during which period the neurological healing takes place. Patients who do not recover during this period require special individual, intensive treatment, and extreme care should be taken to reduce the severity of their problems. Patients should be made to understand that they should be prepared to spend time and make an effort. They must be made to realise that their recovery demands a carefully structured practical plan and its daily implementation.

Denial is a typical and common part of the disease; it subsides as the patient becomes actively involved in treatment and a structured recovery programme. Severe denial that does not respond to traditional treatment methods is not very common.

Denial, if extremely rigid and strong, may come in the way of recovery. Extremely severe denial does not respond to common treatment methods. If such a rigid denial is present, there is a possibility of the existence of other complications. So, special efforts should be taken to diagnose and treat these complications. Otherwise the patient will not recover and there is an increased risk of relapse.

Strong craving may be triggered by accidental alcohol or drug ingestion. At times, a patient may accidentally use a medication with an alcohol-based solvent for a medication that contains a sedative or a narcotic. Such accidental ingestions lead to a strong physical or psychological craving. Therefore every chemically dependent person who comes for treatment should be educated to read the literature which lists the ingredients before consuming anything; he should be structured to come for help in case such an intake occurs.

Multiple drug dependency

Some patients use mood altering drugs along with alcohol. In such cases, specific symptoms of alcoholism may not be present. When such patients abstain, strange addiction-reactions occur. Withdrawal symptoms also become complex. Such multiple addiction complicates the recovery process.

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* These are dealt with in detail in the chapter on 'Relapse'.

These complications, if noticed, should be treated appropriately. During detoxification and also during re-educative treatment procedures, special attention should be given and concentrated focus should be kept on the chemical dependents' use of multiple drugs.

In these cases, normal alcoholism treatment alone will not be effective.

Coexisting physical illnesses

Any other acute illness along with the disease of chemical dependency, produces, high level of stress. If a chemically dependent person also suffers from other diseases like heart problems, or diabetes, he will find it extremely difficult to participate in the normal treatment programme. In such cases, the counsellor should design a recovery programme that can be implemented along with the treatment needs of the coexisting illness.

Chronic pain resulting from diseases like arthritis, backache, migraine headache, etc, can also reactivate the symptoms of post acute withdrawal and ultimately lead to extreme stress. If the counsellor comes across such a case, he should be able to give guidelines about methods of pain reduction and direct the patient to such clinics where specialised treatment along with the necessary treatment for chemical dependency is given.

Coexisting psychological and psychiatric disorders

Sometimes these disorders precede chemical dependency. Sometimes the disorders develop along with chemical dependency, and sometimes they develop immediately after abstinence.

Psychological disorders

Gambling, or betting on horses at the race course are compulsive psychological deviations which need attention and proper counselling.

Adjustment disorders

When the adjustment reaction to abstinence is severe, it becomes an adjustment disorder. This disorder exists when a patient's physical, psychological, behavioural, or social dependence on the chemical is so severe that he is unable to function in that area or unable to complete certain tasks without taking that particular chemical, no matter how hard he tries otherwise.

For instance, the recovering alcoholic at the initial stages of recovery, may not be able to do his job with the same skill with which he used to do it before he started drinking alcohol.

Fear of failure may result in isolation and possible depression. For such patients whose skills are seriously impaired, a concentrated programme is necessary to identify areas of impairment and they should be helped to get out of their rigid denial and fear.

If the counsellor is alert, he can identify the patient's adjustment disorders that create functional impairments and interfere with his ability to respond to treatment. A programme of retraining to overcome the specific dysfunction can be formulated so that these impairments are rectified.

Sex problems

These include inability to perform, lack of interest in sex or total impotence. These also require proper psychological treatment and reassurance.

Psychiatric disorders

If there is any severe psychiatric disorder, the patient will not respond typically during the stabilisation period. These responses should be noticed and carefully evaluated.

Depression (both endogenous and reactive) is the most commonly found disorder that co-exists with chemical dependency. Anti-depressants may be included in the treatment procedure.

Other problems like acute anxiety, indefinable fear, paranoia and suspicion are commonly present. If they are unusually acute, attention should be focussed on these disorders and necessary medication should be given along with the treatment for chemical dependency.

Psychiatric treatment should go hand in hand with the multi-disciplinary treatment for chemical dependency. The counsellor's job is to consult the psychiatrist and counsel the patient according to his particular needs.

Crises situations

The death of a significant person, divorce, occupational problems, getting into a new job, marriage, or a family crisis can create a stress which will lead to a patient's relapse. It is difficult for the patient to face these problems because he has all along been using chemicals to cope with emotional problems. When a patient faces a major crisis, he may need special counselling — grief counselling, marital counselling, job counselling, family counselling — and he should be supported and provided stabilisation to maintain his recovery without an unnecessary relapse.

To sum up,

Recovery from chemical dependency is a very active process which demands a daily, structured, implementable programme.

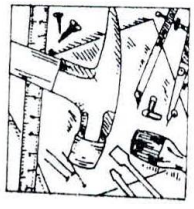
Recovery is

* Totally refraining from mood-altering chemicals
* Getting out of neurological impairments, and organ system damages
* Effecting positive changes in life style and learning to manage problems better.

In short, it means,

LEARNING TO LIVE A QUALITATIVE LIFE AGAIN

Value additions place



— Implementation tool

Sober living

Sobriety means staying away from 'addictive drugs'. It also means improving the quality of one's life.

Addiction must have all along been connected with many habits some at the thought-level and some others at the action-level. Now during sobriety, the chemically dependent person has to develop new ways of **thinking** and **acting.**

It is important for the counsellor to assure the patient that keeping away from chemicals will not turn out to be that uncomfortable, frightening, or impossible; it will really be something he will begin to enjoy and find comfort and peace in.

The following are few tips which can be given as guidelines to the chemically dependent person towards leading a sober life. He can be reassured that these tips have helped many recovering patients and he can also be certainly benefited by them.

Immediate plans to be implemented

— Staying away from the first drink/drug

It is the first drink or drug that does the damage. One cannot stop with a small quantity. It will definitely lead to many more. With absolutely no intention of doing so, the person will find himself abusing the chemical too much. He will find himself right back where he began. The important step in staying sober is to avoid the first chemical intake.

— 24 hour plan

During the days of chemical dependency, the addict would have sworn in the name of his beloved ones that he would never use the chemical again. In spite of his best intentions, he had never been able to keep his promises. He would have inevitably gone back to obsessive chemical abuse.

His experience must by now have taught him that long-term promises do not work. The same pledge will become more successful and implementable if he says, "I am NOT taking the chemical JUST FOR TODAY".

No matter what the provocation or temptation, he can still be determined not to take the chemical — ONLY FOR THAT DAY.

If the desire to use the chemical is very strong, the 24 hours can further be broken down to smaller durations. For instance, he can decide not to use it for one hour..... one more hour..... and so on.

Recovery from chemical dependency always **starts with one sober hour.**

— Postponing the use of chemicals

An uncontrollable craving may occur all of a sudden. At that time, the decision to postpone the use of chemicals may help. Once the idea becomes a part of the chemically dependent person's thinking, he will find this an effective way to achieve sobriety.

— Remembering the last episode of his chemical dependency

When the idea of using the chemical comes to mind, or if somebody offers a drug, the addict should at once visualise the series of consequences that happened after starting with a small quantity of the chemical. He should think down to the last repulsive episode connected with his chemical dependency.

Miseries associated with chemical dependency — losing one's job, torn family relationship, financial damages — every detail should be recalled.

If he remembers the **last repulsive stage** — not the first pleasurable experience, there is a good chance that the thought of using the chemical will automatically disappear.

Avoiding all mood changing chemicals

The recovering person is likely to experience sleep problems during abstinence.

Sleeping pills are no solution for a chemically dependent person. This is actually a real threat to his sobriety. The dependent person is prone to addiction — whether it is alcohol or any other mood altering drug. There is a great possibility that he will get addicted to sleeping pills also.

A glass of hot milk, a warm shower, or deep breathing exercises are some of the methods that can be tried to get over sleeplessness.

— Changing old routines

Certain places, people and time closely associated with chemical abuse should be avoided. These are dangerous traps to sobriety. Many old routines have got to be changed.

For example,

— a different route may be taken while going home from the office, if a drinking place is on the way.

— avoiding parties or meeting friends where liquor or chemicals is likely to be served.

— eating early in the evening and never being on an empty stomach.
— avoiding old friends who abuse chemicals.
— learning to say 'no' whenever chemicals of any type are served. One can definitely be polite and assertive at the same time.

— Eating habits

It has been found that any nourishing food or snack reduces the desire to drink or take drugs. The most important thing is one should never get too hungry. As chemically dependent people are always undernourished, any nourishing food in their stomach makes them feel physiologically better.

— Taking plenty of rest

It is imperative to have plenty of rest when one stops using chemicals because the desire to have drugs is high when one feels exhausted.

It is important that the counsellor should explain to the chemically dependent person that during the early stages of recovery, insomnia is a common condition. There may also be frightening dreams. Gradually the body will get readjusted and all these problems will disappear.

— Always staying with people

Chemical dependency is often referred to as a ''lonely disease''. Therefore, during recovery if an addict starts feeling lonely, the old routines and episodes of abuse are likely to follow.

Staying in the company of family members, non-drinking friends, or relatives will help to drive off loneliness. If a craving for a drink or a drug appears he can immediately share his problems with somebody. He can be assured that the counsellor is always there to help him whenever he has a problem.

Long term plans to be made

— Live and let live

Even when he is off drugs, the chemically dependent person is likely to encounter people who continue to criticise him. His family members, friends, or co-workers are likely to treat him as if he were still abusing chemicals. It may take sometime for them to realise that he has really stopped using drugs for ever. This should not make him feel frustrated, or induce him to go back to chemical abuse.

Just as no one **compelled** him to use chemicals, so no one can **drive him back** to chemical abuse either.

All along, the chemically dependent person had been blaming others for his drug abuse. In sobriety, he should realise that no one else shapes his life.

He should be made to feel that it is in his interest to plan out and enjoy his own life fully and let others live any way they desire.

Staying sober leads to a bright new life. It is worth sacrificing any grudge or resentment to LIVE.

— Getting active

Staying away from chemicals leaves a person with a lot of leisure time. Simply deciding not to take chemicals (without making any concrete activity plan) will not help. He needs new activity plans to fill these blank spaces and utilise his energy which had been previously spent in preoccupation or obsession with his chemical abuse.

While planning, one should make it implementable so that in the end he does not feel tired or exhausted.

The following are a few suggestions:

— taking a leisurely walk or going out with one's wife, children or parents
— visiting AA/NA members and having long chats with them
— visiting friends and relatives
— doing physical exercise
— helping other chemically dependent people by sharing personal experiences as to how to stay sober. This is another way of strengthening one's own sobriety.

— Anger and resentment

Hostility, anger, resentment — all these are powerful negative emotions which pose a threat to sobriety.

Frustration or fear give birth to anger. As a class, chemically dependent people have a very low tolerance towards everything. All along chemicals have been used as a solvent for these emotions.

Anger produces a lot of pent up energy. These should be channelised constructively. Physical activities will provide a healthy outlet for getting rid of anger. Gardening, cleaning the house or taking part in any sport activities are alternatives which may be tried.

Anger, which is a strong impediment to recovery, can be coped with successfully if one can identify the cause of anger and then see whether anger is justified or not.

Modern life is filled with stress. Relaxation, reading and listening to soft music may be tried.

The chemically dependent person should be made to understand that it is afterall his life that is at stake if he gets angry and gives in to the first drink/drug.

— Availing of a sponsor

The idea behind getting a sponsor is that the chemically dependent person has a friendly guide who can call on him whenever he is in need of support — even at night.

A sponsor is only another sober addict, who can help solve one problem — how to stay sober. He has the tool of personal experience in recovery. He will always be willing to reach out and help.

It is good to be able to lead one's own life comfortably, happily, eat and sleep healthily and wake up feeling glad that one was sober yesterday and will definitely decide to be sober today also.

No doubt he has just made a beginning in the process of recovery. The undisputed fact is that chemical dependency is a disease in which relapses are common. In spite of relapses, recovery can be attained if the chemically dependent person strongly determines to get back to life without any chemical. At the same time he should put in efforts to make positive changes in his attitude and behaviour so that he is able to lead a qualitative and balanced life.

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15

SELF-HELP GROUPS*

Self-help groups are voluntary, small group structures formed by peers who come together for mutual assistance in handling a life-disrupting problem. Thus in chemical dependency, self-help groups have been organised by those having problems associated with chemicals. Through mutual aid, members help one another to maintain abstinence and also to bring about desired social/personal change. The various self-help groups founded in the field of addiction are discussed in this chapter.

Alcoholics Anonymous

In this group, members come together to assist each other to help themselves with their drinking problems. This process is more personal and less directive. The individual seeks support from the group, and is also encouraged to seek spiritual help in the form of a personal conceptualization of a Higher Power or God, of one's own understanding.

Preamble

Alcoholics Anonymous is a fellowship of men and women who share their experiences, strength and hope with each other, so that they may solve their common problem and help others to recover from alcoholism.

The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership. They are self-supporting through their own contributions. AA is not allied with any sect, denomination, political organisation or institution; it does not wish to engage in any controversy; neither does it endorse nor oppose any cause. The primary purpose is to stay sober and to help other alcoholics to achieve sobriety.

How did AA get started ?

Alcoholics Anonymous had its beginning in Akron, in 1935, when Bill.W., a New Yorker who was successfully sober for the first time in years, sought out another alcoholic.

* This chapter has been reproduced from various books and pamphlets published by the respective World Service Offices.

During his few months of sobriety, Bill. W had noticed that his desire to drink lessened when he tried to help other 'drunks' to get sober. In Akron, he was directed to a local doctor with a drinking problem. Working together, Bill. W and the doctor found that their ability to stay sober seemed closely related to the amount of help and encouragement they were able to give other alcoholics.

For four years, the new movement, nameless and without any organisation or descriptive literature, grew slowly. Groups were establishing in Akron, New York, Cleveland, and in a few other cities.

In 1939, with the publication of the book 'Alcoholics Anonymous', from which the Fellowship derived its name, and as a result of the help of a number of non-alcoholic friends, the Society began to attract national and international attention.

A service office was opened in New York City to handle the thousands of inquiries and requests for literature that poured in each year.

The twelve traditions of AA

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose there is but one ultimate authority — a loving God as he may express himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose — to carry its message to the alcoholic who still suffers.
6. AA groups ought never endorse, finance or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contribution.
8. Alcoholics Anonymous should remain for ever non-professional, but the service centre may employ special workers.
9. AA as such, ought never be organised, but we may create service boards or committees directly responsible to those they serve.
10. AA has no opinion on outside issues, hence the AA name ought never be drawn into public controversy.
11. As our public relations policy is based on attraction rather than promotion, we need always maintain personal anonymity at the level of press, radio and films.
12. Anonymity is the spiritual foundation of all our traditions ever reminding us to place principles before personalities.

The twelve steps of recovery

1. We admit we are powerless over alcohol — that our lives have become unmanageable.
2. Come to believe that a power greater than ourselves can restore us to sanity.
3. Make a decision to turn our will and our lives over to the care of God as we understand Him.
4. Make a searching and fearless moral inventory of ourselves.
5. Admit to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Are entirely ready to have God remove all the defects of character.
7. Humbly ask Him to remove our shortcomings.
8. Make a list of all persons we have harmed, and become willing to make amends to them all.
9. Make direct amends to such people wherever possible, except when to do so will injure them or others.
10. Continue to take personal inventory and when we are wrong promptly admit it.
11. Seek through prayer and meditation to improve our conscious contact with God, as we understand Him, prayer only for knowledge of his will for us and the power to carry it out.
12. Have a spiritual awakening as a result of these steps, we try to carry this message to alcoholics, and to practice these principles in all our affaris.

Within this framework of human support and spirituality, the above mentioned 12 steps guide the individual to:

— Work towards knowledge and acceptance of self and powerlessness over alcohol.

— Examine and attempt to correct personal defects that might contribute to alcoholic behaviour.

— Reinforce the recovery process by carrying the message to other acutely ill alcoholic persons seeking help.

The AA sponsor

Sponsorship is the continuing interest and responsibility a member takes to support and guide the alcoholic in his decision to quit drinking. The newcomer feels secure to know that there is at least one person who cares, to whom he can turn to, when doubts arise and confidence fails. **A sponsor is not a counsellor**. He is simply a sober alcoholic who helps the newcomer solve one problem — 'How to stay sober'.

and leads from there into a change of behaviour and a change in life structure that interferes with the maintenance of the ongoing recovery programme. The initial change can also be an external event that forces a patient to alter his daily structure and thus increases stress and triggers an internal change of attitude.

Elevated Stress

Change produces stress to which alcoholics are apt to overreact and for which they may have low tolerance.

Denial Reactivation

As stress levels are elevated and become critical, there is a normal tendency to deny the presence of the excessive stress and to reinitiate the denial mechanisms that accompany the disease. When the alcoholic begins using denial patterns to deal with stress, similar to the denial used to deal with the acceptance of alcoholism, other associated thought processes are triggered.

Post Acute Withdrawal (PAW)

Elevated stress intensifies the symptoms of PAW. As these symptoms — thought processes, emotional processes, and memory problems intensify, stress levels are elevated even further (which increases the severity of PAW).

Behaviour Change

As a result of the developing symptoms of PAW, reactivation of denial and chronic elevated stress, the patient begins to act differently. He still goes to the same places and engages in the same activities, but his behaviour invites unnecessary stress and sets the stage for a future crisis.

Social Breakdown

With a change in behaviour, there is a change in relationships. The alcoholic begins to interact in a different way and there is a breakdown in the social structure.

Loss of Structure

Life structure begins to break down. Recovery plans are abandoned, routine and daily habits are altered.

Loss of Judgement

Lack of structure, lack of support systems and increasingly severe PAW lead to confusion, disorder and the inability to solve problems or make decisions. The alcoholic may be emotionally numb or may overreact emotionally.

Loss of Control

The next step is loss of control of thought processes and of behaviour. The person does not make rational choices and is unable to interrupt or modify his actions.

Option Reduction

He comes to believe that he is no longer in control of his life and believes that the only alternatives available to him are insanity, physical or emotional collapse, suicide or drinking.

Acute Degeneration

He returns to drinking or drug use; he may develop stress-related illnesses, psychiatric problems, emotional collapse or physical exhaustion; or he may attempt suicide or become accident-prone.

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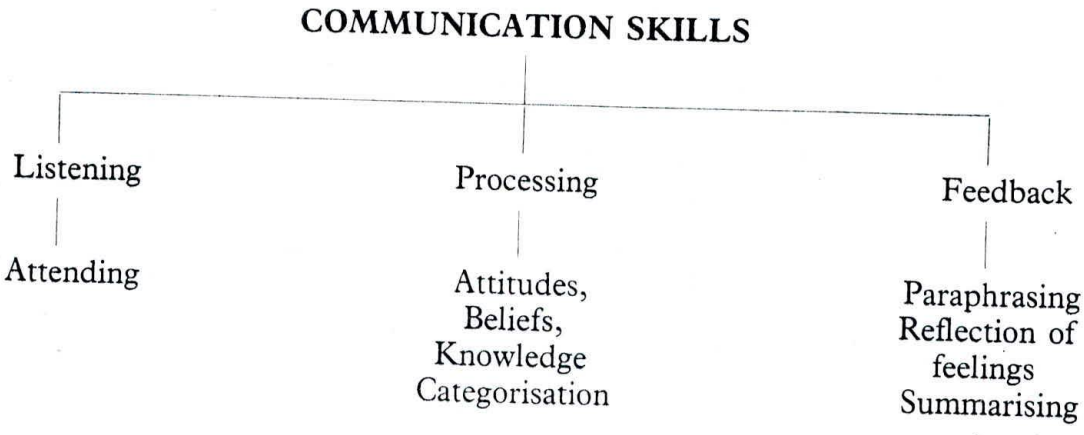
Skills/techniques of counselling

The skills of a counsellor are crucial in the counselling process. Therefore, they must be adequately developed.

The main vehicle through which counselling takes place is **communication**. Therefore developing communication skills is very important for the counsellor.

The **three elements** that comprise communication between two individuals are:

1. listening
2. processing
3. feedback



Listening is defined as receiving messages from a client by focussing attention on what the client is expressing both verbally and non-verbally. **Attending** is a demonstration of concern and interest in the client.

Processing is the complex series of events that takes place **within the counsellor**, between his listening and responding to the client. It may include mentally cataloguing data, beliefs, knowledge, attitudes, feelings, categorization of any factor that influences judgement and performance.

Feedback is the verbal or non-verbal response that the counsellor makes as a result of processing the information received from listening to the client.

PROCESSING

COUNSELLOR ← Listening, Attending ← CLIENT

FEEDBACK

Feedback skills can be broken down into the following:

Paraphrasing: A counsellor's statement that mirrors the client's statement in exact or similar wording.

Client: *My boss doesn't understand me at all. He doesn't realise. I am always shaky in the morning.*

Counsellor: *Mornings are a tough time for you.*

Reflection of feelings: The essence of the client's feelings, either stated or implied, as expressed by the counsellors.

Client: *I didn't want to come here. There is nothing wrong with me. I only came to see you because my wife insisted.*

Counsellor: *You do not seem too happy about coming here.*

OR

I get the impression you are annoyed.

Summarising

This is a brief review of the main points discussed in the session to ensure continuity in a focussed direction. This should be done at the beginning and at the end of each session. In the beginning, the client is asked to summarise the previous session and at the end, the counsellor summarises the main points of the current session.

Researchers in this field have broadly outlined skills specific to the different processes in counselling, but these may overlap and can be used in other processes also.

Skills for data collection	— All interviewing skills, psychological tests.
Skills for identification and understanding of a problem	— Probing, interpreting, confrontation.
Skills for problem-solving	— Processing skills, interpreting, counsellor's self disclosure.

Some of the communication skills have already been discussed. The others mentioned above will be briefly discussed below.

Psychological tests: Psychological tests are standardised tools to obtain a more scientific assessment of an individual's psychological characteristics such as intelligence, aptitude, interests, personality etc.

The counsellor should be familiar with the diagnostic and personality tests, used in the field of chemical dependency. The interpretation of the test scores should be carefully explained to the client.

Probing

A counsellor's response that directs the client's attention inward to help both parties examine the client's situation in greater depth.

Client: *I have been doing this job for years now and nobody ever complained before. Now they are saying my job performance has not been as good.*

Counsellor: *In what ways do they specifically say your work has not been good?*

Interpreting

Presenting the client with alternative ways of looking at his situation. Used effectively, interpreting should assist the client to realise that there is more than one way of viewing most situations thereby helping him to apply this kind of unrestricted thinking to all aspects of his life.

Counsellor's self-disclosure

The counsellor's sharing of his personal feelings, attitudes, opinions and experiences for the client's benefit.

Client: *You know, I feel so ashamed. All my friends are going to find out that I have a problem with drinking and I really don't know how I am going to face them.*

Counsellor: *I understand how you feel, because I can remember how ashamed I felt, at first, when I had to admit to my friends that my father was an alcoholic.*

Confrontation

This refers to the counsellor's statement or question intended to point out contradictions in the client's behaviour and statements — also used to induce the client to face an issue the counsellor feels the client is avoiding.

Other skills

Contracting: Here, the responsibilities and goals of both the client and the counsellor should be clarified either orally or in writing. It is necessary for all clients to acknowledge what is expected of them and to articulate their own goals. A contract should also include penalties for not fulfilling one's part of the bargain. Penalties must be issues that are valued by clients. Contracting helps prevent a situation in which counselling 'drifts aimlessly'.

Referral: Timely, prompt and appropriate referral to other professionals, community resources, is essential in counselling. The counsellor should be aware of other services available to help the client.

Record keeping: This aspect is usually forgotten or taken for granted, but it is a skill of essential value which every counsellor has to develop. Prompt recording of sessions, follow-up notes etc., are essential.

This helps the counsellor in quick reference, and it would help in situations when there is a change of counsellor.

Planning individualised treatment: Here, the counsellor should learn to differentiate, analyse, evaluate and synthesise a multitude of stimuli, communication and pieces of information that emanate from the client, and then tailor intervention strategies.

To summarise, the following are the **therapeutic responsibilities** of a counsellor:

- ☐ Establishing and maintaining a healthy climate for counselling.
- ☐ Taking note of the case history.
- ☐ Preparing the necessary client reports.
- ☐ Seeking consultation with other professionals whenever necessary.
- ☐ Tailoring individual treatment plans.
- ☐ Handling crises situations.
- ☐ Explaining the nature of problems.
- ☐ Helping clients establish contact with community services.
- ☐ Involving/co-ordinating other resource persons in treatment.
- ☐ Preparing after care activities for the client.
- ☐ Evaluating the client's progress, redefining goals if necessary.

Personal qualities of a counsellor

The expert, apart from having a thorough knowledge and perfect proficiency in skills, should also possess the other specific qualities discussed below.

- **A good listener:** A counsellor needs to possess an inherent trait for being a good listener. A counsellor should give up a fondness or 'love for his own voice'.
- **Empathy:** Rogers defined empathy as 'an ability to sense the client's private world **as if** it were your own, but without losing the '**as if**' quality'.
- **Patience:** Patience implies the ability to maintain an equanimity during delays, to remain undisturbed in the midst of obstacles, and to keep a non-complaining calmness during the development of failures.
- **Emotional Maturity** calls for a well-balanced counsellor who does not get unduly swayed.
- **Genuineness:** The ability to experience and share with the client, the feelings which a counselling encounter arouses in the counsellor.

— **Flexibility:** Effective counsellors should be able to adapt both their role and pace according to the client's needs and capacities.

— **Self-disclosure:** Ability and willingness to share any relevant personal experience with the client.

In the field of chemical dependency, a recovering addict who has been sober for more than 3-5 years, with a basic certificate in counselling, can become a counsellor. All the treatment centres abroad utilise such individuals as counsellors. Their personal recovery from chemical dependency is very valuable in guiding other addicts.

Principles to follow in addiction counselling

Apart from the basic principles of counselling discussed earlier, there are some specific ones to be followed in counselling the chemically dependent people. Since chemical dependency is a sensitive issue, strict confidentiality is essential.

— Understand who a chemically dependent person is, what chemical dependency means, its symptoms, etc.

— Recognise that chemical dependency is a disease which affects the family also; hence the entire family needs help and assistance.

— Never refer to the chemically dependent person as a 'drunk' or a 'dope'.

— Confront the client directly with his problems of chemical dependency. Since chemical dependency is a disease, the counsellor should feel comfortable talking to the patient about his abuse.

— The so called 'values' of chemical dependents will be different from those of others. They may even be distorted. The counsellor should be able to accept these as part of the disease.

— Approach a chemically dependent with compassion and understanding and not with logic and argument.

— Relapses can occur during the process of recovery. It is important that the counsellor stays with the client throughout this period. The client needs lot of support and understanding at this juncture.

— Help the client establish short-term goals for recovery.

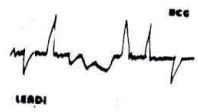
Specific processes for addiction counselling

These can be summarised as follows:

1. Gathering information related to the extent and consequences of chemical dependency. Evaluation of current social circumstances namely occupation, family, finance etc.

2. Explaining to the client and to his immediate relatives the role of chemicals and the relevance of 'dependency practices' and their relation to the present and the past difficulties. Assessment should be shared with the client and his family.
3. Explaining the concept of chemical dependency as a disease to the client, handling denial, making realistic plans, and motivating him to maintain sobriety.
4. Helping clients resolve interpersonal and intrapersonal problems, in accordance with the assessment initially made.
5. Helping the client make sobriety plans — both short-term and long-term. Short-term goals will be to handle the immediate environment that will influence his maintenance of sobriety, and to formulate steps for relapse prevention. Long-term goals will be to help the client make efforts to attain a change in his life style, personality characteristics and values, and plan aftercare measures and long-term follow up.

Value additions place



— Diagnostic tools

Psychological tests

Psychological tests are used to get more information about the client, which will help the counsellor towards a better understanding to enable him to evaluate the problem and make plans for treatment. In the treatment of chemical dependency, the following tests are frequently used.

Multi-phasic questionnaire (MPQ)

This is a hundred item questionnaire, derived from the Minnesota Multi-Phasic Inventory (MMPI). This is a diagnostic test used to detect personality disorders. It primarily measures the following eight traits viz., anxiety, depression, mania, paranoia, schizophrenia, psychopathy (antisocial), hysteria and 'K' scale (lie score).

Any individual scoring above the cut off score in any trait, will be considered to have an accentuation of that personality trait.

Beck's scale for depression

Identification of depression in chemical dependents is important. The scale often used for this is the one evolved by a leading mental health professional called Aaron T. Beck. This is a diagnostic tool and is useful in differentiating between endogenous and reactive depression. This scale has thirteen items, which cover the following signs and symptoms of depression — sadness, pessimism, sense of failure, dissatisfaction, guilt, self-dislike, self-harm, social withdrawal, indecisiveness, self-image change, work difficulty, fatigue, anorexia (loss of appetite). Based on the scores, the client is rated as normal, mildly depressed, moderately depressed, or severely depressed.

Roscharch ink blot test

This again is a diagnostic test, which uses the projective method. The test consists of 10 symmetrical ink blots. The subject is then asked to tell what these ink blots might represent. The responses are then analysed on certain parameters (location, determinant, form, colour, movement, content). Thus the personality profile and underlying psychopathology of the client is obtained.

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19
INTERVIEWING SKILLS

An interview is a 'conversation with a purpose'. It is a counsellor's fundamental technique for both assessment and psychosocial management.

The basic component of interviewing is communication. The underlying philosophy in the field of communication is that it is always occurring; in other words, no person can 'refrain from communicating'.

Communication can be:

Conscious: Communicate with one's full knowledge, intention and understanding.

Unconscious: Communicate without one's full awareness and understanding.

Verbal: Communication by spoken words. This gets most of the attention, often delivers the least meaning and has the least powerful impact — it often protects us from feelings.

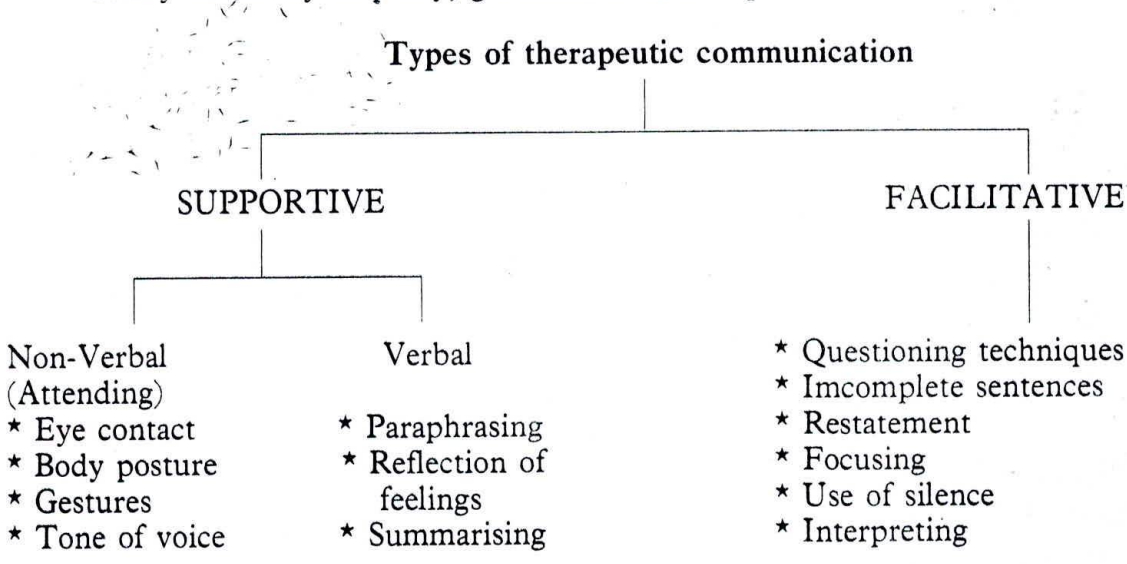
Non-verbal: Communication by gestures, tone of voice, posture etc. This is powerful but its power is very often not fully appreciated. In fact, when there are incongruencies between verbal and non-verbal, it is really the non-verbal part that 'gets across' with greater impact.

In a counselling process, the nature of interviewing done by the counsellor is **therapeutic** and therefore it can be called **therapeutic communication**.

About therapeutic communication

1. It should be a conscious, goal-oriented, planned process of interaction.
2. The nature of therapeutic communication is individualised according to the needs, skills, attitudes and culture of the client.
3. Purposes: Assist the client to
   a) identify his needs
   b) identify his strengths and resources
   c) formulate a plan of action
   d) focus on behaviour for problem resolution
   e) recognise progress, growth, effective coping skills.

4. Pre-requisites:
   a) purpose — an aim with which therapeutic communication should take place.
   b) safety (confidentiality) — to maintain anonymity
   c) belief in potential — belief that the client is capable of change.
   d) agreement — between counsellor and client regarding their expectations i.e., establishing a contract.
   e) conducive environment — includes the physical setting and the counsellor's ability to convey empathy, genuineness and respect.



Supportive communication techniques

These are a collection of skills which form the foundation for all other skills, and which create an atmosphere of support for the client and the process.

Definition of attending

Attending implies a counsellor's concern with all aspects of the client's communication. It includes listening to the verbal content; hearing and observing the verbal and non-verbal cues and the feelings that accompany the communication; and then communicating to the client the fact that the counsellor is paying attention.

Purposes of attending

It encourages the client to continue expressing his feelings and ideas freely.

It allows the client to explore ideas and feelings in his own way and thus provides the client with an opportunity to direct the session.

It can give the client a sense of responsibility for what happens in the session by enabling him to direct the session.

It helps the client relax and be comfortable in the counselling session.

It contributes to the client's trust in the counsellor and sense of security.

It enables the counsellor to draw more accurate inferences about the client.

Components of attending

Effective attending has two components:

1. listening and observing
2. communicating to the client that listening and observing are going on

Guidelines for effective attending

— to communicate listening through frequent and varied eye contact and through 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.

— to avoid talking very loudly

Verbal supportive techniques

Paraphrasing

Paraphrasing is a 'counsellor response' that restates the content of the client's previous statement. Paraphrasing concentrates primarily on cognitive verbal content, that is, 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. Sometimes paraphrasing may involve simple repeating of the client's own words, perhaps emphasising one word in particular. More often, paraphrasing is, using words that are similar to the client's but fewer in number.

Purpose of paraphrasing

It communicates to the client that the counsellor understands or is trying to understand what he is saying. It can thus be a good indicator of accurate verbal following.

It sharpens the client's meaning to have his words rephrased more concisely and often leads the client to expand his discussion on the same subject.

It often clarifies the confusing content for both the counsellor and the client. Even when paraphrasing is not accurate, it is useful because it encourages the client to clarify his remarks.

It can spotlight an issue by statng it more clearly in a few words, thus offering a direction for the client's subsequent remarks.

It enables the counsellor to verify his perceptions of the verbal content of the client's statements.

The **basic components** of paraphrasing are:

1. To determine the basic message that is being expresed in the verbal content of the client's communciation and,
2. To rephrase the verbal content in similar but fewer words.

Reflection of feelings

Reflection of feelings is the counsellor's expression of the essence of the client's feelings, either stated or implied. Here the focus is primarily on the emotional element of the client's communication, whether it is verbal or non-verbal. The counsellor tries to perceive the emotional state or condition of the client and feed back a response that demonstrates his understanding of this state. Reflection of feelings is an empathetic response to the client's emotional state or condition.

The purpose of reflection of feelings

It conveys to the client that the counsellor understands or is trying to understand what the client is experiencing and feeling. This empathy for the client usually reinforces the client's willingness to express feelings to the counsellor.

It clarifies the client's feelings and attitudes by mirroring them in a non-judgemental way.

It brings to the surface feelings of the client that may have been expressed only vaguely.

It gives the client the opportunity to recognise and accept his feelings as part of himself. Sometimes the client may refer to 'it' or 'them' as the source of a problem, when he means 'I was feeling angry'.

It verifies the counsellor's perceptions of what the client is feeling. That is, it allows the counsellor to check out with the client whether or not he is accurately reflecting what the client is experiencing.

It can bring out problem areas without the client feeling pushed.

Components of reflection of feelings

1. Identification — The counsellor must first identify the basic feeling(s) being expressed verbally or non-verbally by the client.
2. Formulation — The second component is to formulate a response that captures the essence of the feeling expressed by the client.

Summarising

'Summarising' is the tying together by the counsellor of the main points discussed in a counselling session. Summarising can focus on both feelings and content. It is appropriate after a discussion of a particualr topic within the session or as a review at the end of the session of principal issues discussed. In either case, a summary should be brief, to the point, and without new or added meanings.

Purposes of summarising

It can ensure continuity in the direction of the session by providing a focus.

It can clarify a client's meaning by having his scattered thoughts and feelings pulled together.

It often encourages the client to explore an issue futher, once a central theme has been identified.

It communicates to the client that the counsellor understands or is trying to understand what the client is saying and feeling.

It enables the counsellor to verify his perceptions of the content and feelings discussed or displayed by the client during the session. The cousellor can check out whether he accurately attended and responded without changing the meanings expressed.

It can close discussions on a given topic, thus clearing the way for a new topic.

It provides a sense of movement and progress to the client by drawing several of his thoughts and feelings into a common theme.

It can terminate a session in a logical way through a review of the major issues discussed in the entire session.

Components of summarising

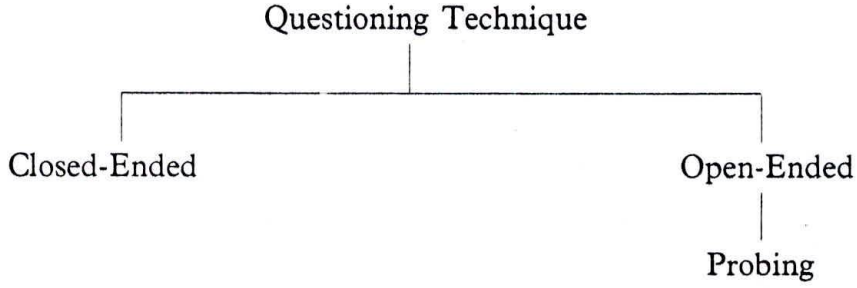
1. Selection — the counsellor uses his judgment to select the key points discussed.
2. Tying together — the counsellor attempts to tie together these points and to feed them back to the client in a more concise way.

Facilitative communication techniques

Facilitative communication skills are used in conjunction with earlier skills and aim to promote awareness, to help in problem solving and to enable growth.

Questioning

Questioning is a skill wherein the counsellor asks the client more details or points to an issue to be discussed.



Closed-ended questions

Closed-ended questions are those which request specific information. They elicit minimal client response characterised by short answers, usually of yes/no type. Closed-ended questions are effective in getting specific answers quickly. However, they are 'counsellor centred' and are not useful in building a rapport. So, if closed-ended questions are used in succession and in large measure, the client can experience the discomfort of being 'interrogated'.

Open-ended questions

Open-ended quetions, on the other hand outline the topic areas generally, without dictating specific responses. These quetions cannot be answered with a 'yes', 'no' or 'may be'. Open-ended questions are 'client centered' and encourage the client to continue communication of thoughts and feelings. Open-ended questions cannot, however, be effective without the client's cooperation. If used beyond an optimal level, it can result in rambling conversations and a lack of focus.

Probing

Probing is a counsellor's use of question or statement to direct the client's attention inward to explore his situation in more depth. A probing question, sometimes called an 'open-ended question' requires more than a one-word (yes/no) answer from the client.

Purposes of probing

It can help focus the client's attention on a feeling or content area.

It may help the counsellor to understand better what the client is describing, by giving him more information about the client's situation. 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 or feelings.

It directs the client's attention to areas the counsellor thinks need attention.

The basic components of probing are:

1. To identify areas that the client has raised which need further exploration and
2. To phrase open-ended questions beginning with words such as what, where, when or how.

Cautions to be taken

While employing the technique of questioning, the counsellor should be cautious to avoid certain questions which raise doubts, create any uncertainty and are difficult to answer. These are:

Rhetorical questions — questions that include the answer. Rhetorical questions can effectively silence the client by communicating that they had better agree with you.

Why questions — questions that begin with 'why' and call on the client to immediately defend himself.

Either/or questions — those which offer (allow) two choices based on an assumption.

Double questions — those questions which limit the client to two choices.

Bombarding (overloading) — the counsellor asks so many questions so quickly that the client doesn't have the opportunity to sort out thoughts and is not given a chance to express himself.

When to use questions

The counsellor can use questions when he doesn't understand, can't hear or wants to make sure that he is understood. Questions are also useful to clarify, explore a thought or gather more information. A conversation can be redirected or a silence ended with a question.

When not to use questions

A counsellor should not use questions to establish authority. Moreover when the counsellor does not intend to listen, a question should not be asked.

Additional 'brief' facilitative techniques

Incomplete sentences: This is a skill wherein the beginning of a sentence is used, to encourage the client to continue after a pause (e.g. "And you feel....")

Restatement: This is literally repeating the last word or few words the client has said, to encourage continuance (e.g. "Feeling pretty angry.....")

Focusing or refocusing: Pointing out or giving careful attention to the main theme or feeling that the client had been sharing before the diversion. (e.g. "You were telling me about your first NA experience").

Silence: Silence can be very powerful. It can be a time when things really have a chance to 'sink in', or for feelings to be really felt. When combined with 'attending' cues, it can serve to encourage someone to continue sharing. It can allow the client to experience the power of his own words.

Interpreting

Interpreting is a technique used by the counsellor to present the client with alternative ways of looking at his situation.

Purposes of interpreting

It helps the client realise that there is more than one way of looking at most situations, problems and solutions.

It offers the client a role-model counsellor seeking alternative ways of viewing events in life.

It can teach the client how to use self-interpretation to explore new points of view.

It can help the client understand his problems more clearly.

It often generates new and distinctive solutions to problems.

It may prompt the client to act more effectively when he offers solutions to problems.

It often enables the client to gain a better understanding of his underlying feeling and how these might relate to verbal messages he has expressed.

Basic components of interpreting

— Determining and restating basic messages
— Adding counsellor ideas for a new frame of reference
— 'Checking out' these ideas with the client

Whether the counsellor is exactly on the target or not, the client is more likely to react to an interpretation openly if it is offered tentatively.

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20

PROFILE OF CHEMICAL DEPENDENTS

Drug dependents

While it is widely accepted that drug dependents can come from any walk of life, incidence seems higher in certain groups rather than in others. It is possible to discern just a few similarities among drug users. These are at their best only generalisations and not the rule. Being aware of this, will make us more alert in identifying addiction when dealing with groups with a high incidence of drug dependence.

Sex: The majority of drug dependents are males and the percentage of females is very low, though not negligible. While alcohol is more likely to be abused by men, a casual misuse of other depressants (e.g. valium) is more common among women.

Age: In contrast to alcoholics, most of the ganja and brown sugar dependents are very young — in their late teens or early twenties. The greatest risk of initiation into 'illicit drug use' is usually over by the mid 20's. In a study of college students in Bombay, the age of most drug users was found to be between 19 and 24 years.

Sedative hypnotic drugs are mostly abused by people in their 30's and 40's.

Education/occupation: Youngsters who try illicit drugs, usually have a prior history of poor school performance and lack of motivation and initiative. Prevalence studies conducted in India, showed that drug abuse was higher in students who lived away from their families — in hostels etc.

Of professionals addicted to legal drugs (other than alcohol) physicians and other health care professionals show higher rates of addiction. The easy accessibility of narcotics and other potent drugs and the stress of the medical profession are probably reasons behind such a high rate.

Economic status: Contrary to the common misconception that addiction is limited to the elite class, drug addicts can come from any socio-economic background. However, brown sugar addicts come mainly from the middle and higher socio-economic level. The prohibitive cost seems to be the factor behind such a representation.

Ganja being cheaper and more readily available, ganja dependents come from any socio-economic level.

Abusers of medically prescribed drugs are mostly from the middle or high income groups.

Types of drugs abused: Illegal drugs are more commonly abused by the younger population. The use of legal drugs like alcohol almost always precedes the use of illicit drugs.

Exposure, availability and price seem to be important factors in determining the type of drug abused.

Prevalence studies conducted around a decade earlier, reported that alcohol and pain-killers were the most commonly used categories of drugs. Brown sugar did not even find a mention in the study. Around 1% of the students used cannabis. The drug scene has changed considerably over the past five to six years, with brown sugar and ganja being the commonly abused illicit drugs.

Teenage drug use: An adolescent's choice of whether to try alcohol/drugs or not, results from a complicated mix of feelings and values arising out of certain personal and social factors. Curiosity and peer-pressure are the most common reasons behind illicit drug use.

Recent research findings in the West point to the fact that a particular social structure and behavioural patterns are predominant in those who try drugs. It has been concluded by experts, that no one personality trait is responsible for making a person a drug dependent. A combination, however, may make him more prone to addiction.

1. The age when drugs are first used is a major pointer to serious drug abuse. The younger the person when drugs are first used, the more serious will be his involvement with drugs.
2. Immaturity and maladjustment seem to precede rather than follow drug use.
3. They often skip classes, have a low self-esteem and seem to suffer from a feeling of alienation.
4. Greater susceptibility to peer influence, a certain amount of rebelliousness and a need to display their non-conformity are usually noticed.
5. Drug-abusers seem to go through a period of anticipatory socialisation — that is, they start developing attitudes favourable to use of drugs.
6. Favourable attitudes towards drug use and actual drug-taking behaviour among his peers lead to his subsequent involvement with drugs.
7. Young users of legal or illegal drugs often lack a sense of positive involvement and attachment to their family relationships. In one study of the family pattern of male narcotic addicts, the presence of a dominant, over protective mother and an indifferent, uninvolved father were identified.

Thus we see that it is possible to group some people based on a common history and environment and predict whether they will use drugs or not.

When drug use turns obsessive and chronic, changes in various facets of the person's life can be noticed.

Physical appearance

- Poor appetite and loss of weight
- Haggard look, dull and apathetic
- Poor personal hygiene and poor grooming
- Wears ear rings, bracelets or chains with unusual pendents in an attempt to prove his oneness with other drug users.

Psychological state

- Interest in other leisure activities declines. Playing tennis, chess, or other hobbies do not seem to interest him any longer.
- Becomes interested in rock music and other types of music that extol drug use.
- Expresses and believes in myths connected with drugs. He may feel that drugs increase creativity or that he is 'real cool' with drugs.

Value systems

- Spiritual pursuits decline. Involvement in spiritual activities diminish.
- Tells lies frequently and may even cheat people to get money to buy drugs.
- May steal articles to pawn or sell. Initially these are things that will not be noticed easily. Slowly even obvious pieces start disappearing.
- Some resort to 'pushing' or 'peddling' drugs to earn money to maintain their supply of chemicals.

Family relationships

- Dull, withdrawn. Prefers to spend time all alone.
- Communication with others is reduced and is secretive.
- Inexplicable mood shifts are noticed.
- Very irritable when questioned about his behaviour. Rebels against any kind of discipline.
- Tells lies when asked about his whereabouts.
- Excuses himself from family gatherings, outings etc.
- Makes increased demands for money (very noticeable, if 'on brown sugar')

Education

— Poor attendance at school/college
— Poor academic performance
— Spends little or no time with his books

Friendships

— Initially drug taking starts as a group behaviour. So the user looks for and finds friends who take drugs regularly.
— Spends a lot of time with his new found 'friends'. They may be school dropouts, rebellious and generally not the kind of people one would like to have around.

Alcohol dependents

What is a typical alcoholic like?

Sex

The majority of alcoholics seen in the treatment centres and AA meetings are middle aged men (35 — 45 years old). They seem to start their "social drinking" at the age of twenty five, and continue drinking excessively for at least a period of ten years. However, they come for treatment only after they get into the middle or chronic stage of alcoholism. The incidence of female alcoholics is low, though not negligible.

Education/Occupation

Educational background does not seem to have any significance. From the illiterate slum dweller to a highly specialised professional, anyone can and does develop alcoholism.

Alcoholics are found in all strata of society. Factory workers and people who are subject to physical labour (masons, other daily wage earners etc) are found to abuse alcohol. Senior executives and people on the sales job who are subject to tension and stress also resort to the use of alcohol, in the course of time some of these individuals end up as alcoholics.

Types of liquor abused

Most of the alcoholics seem to start their drinking experience with taking beverages like beer; then proceed towards brandy, whisky, etc., and finally end up drinking cheaper and more potent beverages like arrack. In short, they proceed from lighter beverages to 'hard liquor'.

When alcohol use turns inappropriate and excessive, changes in various facets of his life can be noticed.

There are certain personality traits distinctly found in alcoholics. Nevertheless no single characteristic or cluster of traits is common to all alcoholics.

The personality traits include:

— low frustration tolerance
— weak ego strength
— emotional immaturity
— impulsive
— inability to accept failures
— highly sensitive

These personality traits seem to precede and also follow alcoholism.

So far as the alcoholics are concerned, some generalisations can be made.

Physical appearance

— Haggard, week and sickly look
— Bloodshot eyes; bags under eyes
— Red nose
— Puffed face
— Pot belly
— Tremors
— Poor personal hygiene (Unshaven face; unclean dress).

Psychological state

— Totally denies that he has a problem with alcohol or gives excuses.
— Blames others for mistakes committed by him.
— Justifies his inappropriate behaviour.
— Exhibits gradiosity — talks 'big' about himself or gives others much more than what he can afford.
— Over sensitive even to minor criticism.
— Feels depressed.

Family relationships

— The majority of alcoholics stay with their family, even though their relationship is absolutely strained.
— Some of them get separated off and on.
— Alienation from relatives.

- The alcoholic and his wife constantly fight with each other.
- Has extramarital relationships.
- The alcoholic is apathetic and passive especially when he is required to take up responsibilities.
- The wife plays the role of the husband.
- Verbal abuse and physical violence ensue.

Friendship

- Stays away from 'old' non-drinking friends.
- Normally withdrawn and prefers to drink alone outside his house.

Value systems

- There is a total breakdown in ethical standards.
- In the chronic stage of alcoholism, he goes to any extent (begs, borrows or steals) to maintain his supply of alcohol.

Society

- Becomes aggressive.
- Causes serious problems to others when he drives in a drunken state.
- Gets involved in legal fights.
- Displays anti-social behaviour.

Work place

- Frequent absenteeism.
- Marked deterioration in work performance.
- Has problems with inter-personal relationships.
- Gets memos, suspension orders or is fired.
- Changes jobs frequently.

Financial

- Is a master at giving excuses and taking all sorts of loans from the office.
- Pawns wife's jewellery to obtain his supply of alcohol.
- Borrows money from friends and relatives.
- Sells off jewels, household articles and property if any.
- Is always in debt.

These changes by themselves do not indicate chemical dependency. However, if a combination of these is repeatedly seen over a period of time, addiction to alcohol or drugs can be identified as the cause.

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MOTIVATING THE CLIENT

Motivation is one of the key issues in the treatment of chemically dependent people and it is the first phase of therapeutic treatment. 'Motivation' can be defined as the desire to change one's own dysfunctional behaviour. In this context, it may be said to include the following:

— giving up drugs
— desire to make changes in one's life style
— realisation that it is essential to take an active part in the treatment programme
— willingness to make adjustments in order to recover.

The motivation of a client can be assessed, based on the following factors:

— Accepting that there is a problem with chemicals
— Asking for help for the same
— Reporting for treatment without coercion
— Compliance with the terms laid down by the treatment centre
— A past history of abstinence
— Internal locus of control (i.e.) a desire to get better for one's own sake.

Chemical dependents generally come for treatment only when they are left to face some crisis all by themselves — loss of job, marital dissolution or legal threat. When the client meets the counsellor for the first time, he will have a very low motivation. He will not admit, under any circumstances, that he has a problem with chemicals. Initially, the client will focus attention on his immediate problems like his loss of job, separation from his wife, etc. The most important thing is that the counsellor should show understanding and reassure the client that his problems will be looked into.

It is not advisable to try and make him understand that chemical dependency is his real problem because the client, at this juncture, will be experiencing severe stress, arising out of acute fear — fear of withdrawal, fear about the kind of treatment he is going to be given, fear about others coming to know about his problem, etc.

"How am I going to face the physical problems associated with withdrawal?"

"What kind of treatment are they going to give me? — Operation? — Electric shock?"

"How am I going to face my 'old friends and neighbours'?"

It is important that these inner barriers which prevent him from admitting his need for help should be recognised and discussed with empathy.

If at all the professional wants to focus his attention on chemical dependency, he should start talking to him about his obvious physical problems like tremors, loss of appetite, and noticeable weakness. He should concentrate only on the physical damages which are obviously seen.

The client would already have taken treatment, in various centres, and failed to recover. Therefore, his acceptance of treatment will be minimal. He would already have tried (though unsuccessfully), to stay away from chemicals. He would have experienced problems associated with withdrawal. Meeting other recovering patients at the treatment centre and talking about his internalised fear will also help him overcome his anxiety. The recovering patients will talk about the intense fear they had during admission, and give him reassurance that a safe withdrawal is possible.

Most of the chemically dependent people have a 'motivable area', which is a sensitive area that has to be identified by the professional. The client may have very warm feelings towards his parents, employer or child. These sensitive areas have to be identified and can be done by attentive and non-judgemental listening — listening to his verbal and non-verbal communication.

"I have come for treatment mainly because my mother is very upset and worried about my ill health!"

"I want to give up drinking because I find that my drinking upsets my daughter. I will go to any extent to keep her happy."

These motivable areas can be located by encouraging the client to talk about all his feelings — the relationships he respects and wants to strengthen.

The counsellor's most important task during the first interview is to establish a positive relationship. His understanding, non-condemning, non-judgemental attitude, his acceptance of the addicted client, will in turn, help the latter to accept himself. He will be able to overcome his guilt feelings, his self-hate and his self-destructive tendencies. Once the client feels accepted, it will be relatively easy for him to discuss his problems freely, the mere mention of which would earlier have irritated him.

By now, the counsellor should have gained the acceptance of the client. His motivation has now got to be strengthened and reinforced. The following methods have been tried and found to be useful to enhance the patient's motivation.

Verbalisation and feedback of the damages caused by chemical dependency in the different areas of his life can now be addressed. This can be done in individual counselling sessions.

Participation in group therapy and interaction with other chemically dependent clients who have abstained for quite sometime, will give him the reassurance that he is not 'alone'. He will come to realise that others had the same or similar problems and that they are able to lead a better life without the chemical. He will be reassured that abstinence is possible.

Video presentations have been tried abroad and found to be very effective. This involves a video recording of the patient's behaviour under intoxication and replaying it to him when he is sober. This method is a little expensive, and therefore not being tried in India.

The client should be encouraged to read materials which give comprehensive information about the disease of chemical dependency. An open discussion of the successful recovery of other patients may foster additional optimism in the client who has had a history of prior treatment failures, or who is doubtful about the successful outcome of treatment.

Another method which is used for motivating the client, is involving individuals whom the client holds in high esteem. Their involvement in the treatment process will increase the motivation of the individual. Friends or employers who are genuinely interested in his wellbeing may prove to be strong sources of support.

The technique of inducing fear and coercion has also been used. Diagnostic tools like blood reports, CT scans, and X-rays with a proper explanation from a medical professional will make him realise the physical damages caused by his chemical dependency. However, this technique has to be adopted with extreme caution.

There may be chemically dependent people who do not respond to any of the above stated motivational procedures. For them, the emotional acceptance of the fact will take a very long time. The counsellor may be challenged by them again and again. The strength of his 'acceptance' will be tested on numerous occasions. Instead of rejecting the clients or confronting them with logic and argument, the counsellor should reassure them that they are always there to help and support them and that they are welcome at any point, if only they decide to take treatment.

To conclude, acceptance of treatment by itself does not mean that motivation is strong. Constant follow up and contact with the professional is necessary to sustain motivation which in turn will lead to a commitment to recover.

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CASE-HISTORY TAKING

Case-history taking is a process of data collection and a clinical interpretation of that data. In other words, it is an assessment of a client that includes his abilities, strengths, needs and resources as well as his weaknesses, stresses, problems or danger areas. This is the first step in the formulation of a treatment plan, and is an ongoing process in the therapeutic relationship.

Interviewing the chemically dependent

As assessment interview of a dependent can be conducted in the treatment centre, home, school, college, workspot etc. The counsellor should take this interview as an opportunity to plan what kind of intervention or treatment might be most appropriate and effective.

How to conduct the interview will vary depending on whether or not the person being interviewed admits he has a chemical dependency problem. In either case, the chemical dependent will often play down his problems and may try to get rejected by the counsellor, the very person to whom he has come for help. On the other hand, his abuse exploits may occasionally be exaggerated out of bravado. Given an environment of empathy and understanding, chemical dependents tend to be honest and open.

The interview *per se*, may be a threatening prospect for the chemically dependent. It has been found useful to convey to the client that counsellors do realise their difficulty in talking freely about dependence. Here, the counsellor can emphasise that talking about the problem is the way to get help. Beginning from where the client perceives discomfort and proceeding from there is also useful.

The client needs to feel that "I am providing information not to a computer, but to another human being who is sensitive to my needs, respectful of my concern for privacy and supportive of my desire for change". Assurances given by the counsellor should be totally honest.

Chemical dependents are often quite fragile from the psychological point of view, and thus have set up so many defences that it is easy to underestimate how troubled they really are. The counsellor should be aware of these:

Rejections

Chemical dependents may want to be rejected by the counsellor, or may find reasons why they should reject the counsellor so that they have ample justification to leave the interview and carry on their substance abuse. The defences used in rejection fall into several categories.

You are no good, you don't know anything. At the interview, chemical dependents often test out their counsellor. Thus, to establish a good rapport with clients it has been found that the discussion of the following issues evokes empathy — physical effects (withdrawal), physical damages, life style, etc.

You are no good, you are as bad as me. Counsellors should be prepared to face the question "Do you drink", from their clients. An honest reply is probably the best.

You are no good, you can't cure me! In many instances, the chemical dependents would have already seen a number of people who would have tried, unsuccessfully, to help. It is a defence mechanism which reflects feelings of despair. The counsellor can be positive, reassuring and give direct advice here.

Denial

A defence mechanism which occurs at the unconscious level, wherein the client attempts to play down his troubles and problems.

This has been extensively discussed in Chapter 8.

Components of case-history taking

Before beginning the assessment interview, it is worth deciding what exactly is to be elicited. These include:

1. Complete details pertaining to the socio-demographics of the client to be noted down. This will not only help to establish a rapport with the client, but would also make records complete.
2. Details about drinking, first drink, drinking status, intensity, extent of compulsion and a brief note on central nervous system sequelae of drinking.
3. Details about drug taking including type of drugs and pattern of use.
4. Psycho social damages of drinking/drug taking covering psychiatric problems, drunken driving, arrests, accidents.
5. A detailed history of family origin including family history of mental illness, alcoholism, drug dependence.

6. Educational history of the client in detail, level of academic performance, extra/co-curricular activities, failure if any, and other relevant issues.
7. Detailed occupational history including the number of job changes, reasons for the same, current employment, salary, level of job satisfaction, problems if any with employers.
8. Details regarding financial status.
9. Marital history, details pertaining to the nature of marital relationship, relationship with children, other problems.
10. A detailed sexual history of the client including history of masturbation, premarital, extra-marital relationships, problems in performance.
11. Complete medical history, coupled with a detailed physical examination including neurological examination.
12. Laboratory investigation, psychological test reports.
13. A summary highlighting relevant and important details.

Eliciting problem areas

The purpose of case-history taking is to secure as much information as you need to understand the client, his problems and strengths.

Having collected information about the client in three broad areas — physical, psychological and social, the next phase is to organise this information and assess the problem areas and needs of the client. This will help the counsellor to assess the following:

a) What are the client's strengths and weaknesses?

b) What are the client's patterns of coping?

c) Is the identified problem the real problem?
   i) What are the individual/family dynamics?
   ii) What are the needs?

d) Is the problem acute or chronic and to determine
   — the urgency of the problem
   — dangerousness of the situation
   — the client's perception of what bothers him the most.

The counsellor should investigate further in depth into those areas where the client may be coping poorly. The technique of probing would be extremely useful here. The counsellor should note that each client's problem areas would be different, and therefore, time should be spent with each client individually for eliciting problem areas.

The unearthing of problem areas is done not merely by gathering information from the client, but also from his family members, collaterals, employers, other agencies, and professionals. What the counsellor observes (tone of voice, affect, facial expression etc) is also of prime importance.

The counsellor should remember that people in trouble need someone to listen to their problems attentively, support their decision to seek help and offer a systematic way to assess their difficulties and suggest methods to cope with them. Case-history taking is the time when someone is encouraged to talk about himself, perhaps for the first time. This alone can often be an effective way of getting someone to change his drinking/drug taking behaviour and his way of life.

It is important to remember that if a full assessment is made right at the beginning, there is the best chance of making the right decision about what to do.

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DEALING WITH DENIAL

The concept of denial has been discussed in detail in one of the previous chapters. The types of denial discussed are blaming, justifying, minimising, intellectualising and silence. Here we will discuss how these forms of denial can be handled.

The handling of 'Denial' goes through specifically distinct phases.

In the initial phase (i.e. at intake), when the client comes for help, it is important for the counsellor to **accept** the client's denial. The individual may have a very poor motivation and may give reasons other than chemical dependency for seeking help. Blaming, justifying and minimising should be considered as part of the disease. When the client uses these defenses, the counsellor should be aware of these and at the same time, not fall into his trap. Acceptance of denial for the time being and emphasis on the beginning of treatment, are of importance here. During this phase, the counsellor should avoid referring to the client as an alcoholic or an addict. Instead, he can use phrases like 'problem drinker/drinking', etc.

The next step would be to establish a contract with the client that he is always welcome and that he can come back for help whenever he feels the need. It is important to maintain a non-threatening and supportive counselling climate.

The next phase would be the warming up phase. The goal here is to establish a therapeutic relationship. Many a time, the client may provoke the counsellor. Qualities like patience and tolerance expected of a counsellor, should predominate here.

After entering the treatment programme, the client attends re-educative lectures on topics like 'The Disease concept of chemical dependency', 'Denial', 'Personality traits', 'Damages', etc. He also attends group therapy sessions. In approximately ten days' time, the client's denial would have been broken down to a large extent. Lectures, group therapy and counselling sessions would have facilitated this.

The next crucial phase is **confrontation,** and this must be carried out after proper evaluation. If after attending lectures and group therapy sessions, the defenses of the client have already started breaking down, confrontation in individual counselling sessions may not be necessary.

Confrontation is the crucial technique through which denial is handled at later stages.

Confrontation

Confrontation is the deliberate use of a question or a statement by the counsellor to induce the client to face what the counsellor thinks the client is avoiding. The client's avoidance is usually revealed by a discrepancy or contradiction in his statements and behaviour. Thus confrontive responses point out discrepancies either within the client or in the client's interaction with the environment. In confrontation, the counsellor frequently identifies contradictions that are outside the client's frame of reference. On the other hand, paraphrasing, reflection of feelings and summarising involve responding within the client's frame of reference. In using confrontation, the counsellor gives an honest feedback of what he perceives is actually happening in the client. Confrontation should not include accusations, evaluations or solutions to problems.

Types of discrepancies

A discrepancy in the client is often a clue that confrontation is necessary.

1. A discrepancy between how the client sees himself and how he is seen by others.

   Thirty-six years old Ranjit was running a small business firm. He got into excessive drinking and gradually started neglecting his business. 'He stopped going to the shop', as a result of which, his business suffered a great loss.

   He was brought to the Treatment Centre by his brother, Vijay.

   In one of the individual counselling sessions, Ranjit repeatedly complained, "Nobody allows me to continue my business. I am never allowed to meet my suppliers. I am scared that my business will come to a halt."

   In another interview, his brother Vijay said, "During the last 6 months, Ranjit went to the shop only on two occasions. He did not meet a single key customer or supplier during this period. In fact, on one occasion, when a customer well known to Ranjit dropped in at home, Ranjit never came out of his room even to say hello to him. It put a strain on my old father who had to be a standby for Ranjit. In spite of our daddy's persuasion, Ranjit refused to go to the shop."

2. A contradiction between what the client says and what his behaviour indicates.

   Sanjay told the counsellor, "I am desperately on the look out for a job for the last three months. I want to be able to support my wife and children. I must get a job as early as possible."

   Subsequent interactions revealed that he had not sent even a single application to any company during the last three months. He had not approached anyone to discuss or talk about his job. He was doing nothing but watching video programmes. Still he kept on saying he was hopeful of getting a job.

3. A discrepancy between two statements made by the client.

   Rakesh would write his assignments extensively and admit that drugs had been a problem in his life and that he had incurred damages due to abuse. When asked in individual sessions, he would deny the above.

4. A discrepancy between what the client says he feels and how any other normal person is likely to feel in a similar situation.

   Kadhir had been drinking excessively for three years as a result of which he lost his job. His wife found life unmanageable and therefore left him.

   He took treatment and abstained from drinking for six months. With great difficulty, his sister got him a job as a driver. She also helped by getting him a small house for rent. She spoke to his wife, and assured her that he would become responsible. His wife joined him.

   At the end of the month, Kadhir got his salary; went instantly to the arrack shop and drank. Within a few days, he got back to excessive drinking, and consequently lost his job. This incident really shook Kadhir's wife.

   Kadhir was again brought to the treatment centre. When asked about his occupational problems, he casually replied, "I am not at all worried; I can always get a job. It is only a matter of a few days!"

5. A contradiction between what the client now says he believes in and how he has acted in the recent past.

   Suresh often stated that staying away from the bottle was no problem, but he had three slips last month.

Areas to assess before employing 'confrontation'

— Firmly establish empathy and mutual trust as part of the counselling relationship.

— Confrontation should be a positive and constructive act, and not a negative and punitive act.

— The counsellor should address specific, concrete attributes of the client's behaviour, so that the client can take steps and do something to change.

— In deciding whether to confront or not, the counsellor must weigh the possible benefits to the client against retaliation.

— Prepare other family members, if they are also to be involved in the confrontation of the client.

Types of outcome

- The client may accept the confrontation, in which case, the counsellor should reinforce the client's acceptance positively.
- If the client defies confrontation, it is probably wise for the counsellor to return to an empathatic response. But it is essential to convey to the client that "We maintain what we say". Confrontation may be tried again in later stages.
- The client may simply act confused or ambivalent after a confrontive statement, in which case the counsellor could focus on current feelings.
- The client may decide to break the relationship. It is essential that the counsellor is in touch with his feelings and emotions, especially when the client retaliates or tries to break the relationship. The counsellor must take solace in knowing that he has done everything that could be reasonably expected of him.

Where to confront

Confrontation can take place in three settings:

- Individual counselling sessions
- Group counselling sessions
- Individual sessions with the medical practitioner.

In the individual session, the counsellor can handle the client's psychological defenses, personal problems like marital relationship, personality traits, etc, and help him in making changes in his life style.

In the group, other group members may confront the individual. Here denial pertaining to acceptance of chemical dependency, signs and symptoms of chemical dependency, pattern of drinking and damages incurred are best handled.

The medical practitioner, by showing the objective bio-chemical and other reports, can confront the client regarding his pathological drug taking behaviour and the physical damages caused.

How to confront

Confrontation is a technique which has to be employed with tremendous caution. A counsellor should go through the process given below before confronting a client.

- Establishment of an empathetic relationship is essential. Good rapport is a prerequisite and the counsellor should convey to the client that he is cared for. Mutual trust should be built.
- The counsellor should collect exhaustive information about the client. This is done by talking to the client himself, to his family members and to other significant people (e.g. employers).

— Discrepancies in the above information between the details given by the client and the details given by others should be identified.

— At this point, the counsellor can cross-check with the client about the discrepancies, but this should take place in a casual, non-threatening manner.

— If the previous step has not been successful, the counsellor should weigh the possible benefits and losses in case the client is confronted.

— Timing is the most important factor in confrontation. A client who has just entered the treatment programme or a patient who is just preparing for discharge should not be confronted.

— If other people are to be involved in confrontation, (e.g. family) they should also be informed and prepared for the same.

— Actual confrontation should always have its emphasis on the need for change. The whole process should be carried out in an empathetic, caring and supportive climate.

— Assessment of outcome and appropriate reinforcement should be made.

— The counsellor who is inexperienced or not confident of his professional competence, would also be anxious before and after confrontation. These feelings have to be recognised and appropriately handled, by discussing with senior staff of the centre.

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GROUP THERAPY

The health field has used homogenous groups to enable clients to share common concerns and gain therapeutic benefits through the concept of universality. It has been contended that homogenous groups help members assume responsibility for themselves and handle emotional responses to problems such as depression, guilt, aggression and dependency. Groups provide an opportunity for people to discover that they are not so odd, different or so alone with their problems as they think.

In the treatment of chemically dependent people, group therapy is one of the techniques most recommended, since it deals with the multiple aspects of chemical dependency.

What is group therapy?

'A group' is a collection of individuals with similar problems. Group therapy helps them to discuss/share their experiences with one another, and through this process, learn skills of coping, decision making and problem solving. In the treatment of chemical dependency, the group participants consist of persons who are dependent on any chemical — alcohol, ganja, pethidine, etc. Participants' age, occupation or social class may vary.

Goals of group therapy

The general goals of group therapy for chemically dependent clients include:

- Accepting the fact that chemical dependency is a problem.
- Recognising the existence of other problems related to chemical dependency.
- Attempting to break denial.
- Becoming aware of and identifying feelings.
- Enhancing motivation.
- Accepting personality defects and making attempts to change.
- Helping him change his life style.
- Improving interpersonal relationships.
- Learning new ways to respond to problems.
- Assisting him maintain abstinence.

The process of group therapy

The optimal number in a group is 10 — 12 members with one or two counsellors. The group can meet for one hour five days a week. The group can either be closed or open. In a closed group, no new member is allowed, and the same members continue throughout the programme. In an open group, new members can join in. Members are seated in a circle and this has a significance which clients should understand. Sitting in a circle symbolises that all clients in the group are equal. It also facilitates 'face to face' interaction. The session can begin with the counsellor explaining the group rules and purpose in brief and enabling group members to get acquainted with each other. The general rules are

— to maintain strict confidentiality

— to be as honest as possible

— to focus sharing on the topics which are being discussed

— to talk to the whole group

— not to interrupt when somebody is sharing

— to be regular and punctual and to inform if unable to attend

— not to leave the group in between a session.

All participants are considered equal, irrespective of their drinking/drug taking status or nature of the damages. The counsellor, as a facilitator of the group, need not share any details regarding himself.

Therapeutic tasks

Backing the earlier mentioned goals are the therapeutic tasks. These tasks include:

★ Helping clients verbalise their drug taking episodes and their consequential adverse behavioural experiences. To enable the same, a structure can be provided in each session in the form of a topic being decided for the group. The topics can be flexible — depending on the stage of the group and can include problems like damages, feelings, worst drug taking episode, past adverse life style, symptoms of chemical dependency, denial, powerlessness and unmanageablity, commitment to change and problems in sobriety.

★ Helping the client begin working through the mechanism of denial, thereby making the gradual emergence of reality possible. To protect himself from painful feelings, unpleasant insights and personal accountability for problems, the chemically dependent person develops a rigid defense system, and denial is the hallmark. The group medium has proved to be an exclusively effective tool in breaking this system.

★ Using interpretation to enable the client connect his past and present actions and recognise the inappropriate aspects of his behaviour.

The clients who are in the first phase of group therapy can be allowed to focus on damages, and on similar concrete, identifiable issues in the midst of a supportive and accepting group, which acknowledges concerns and physical effects. Members are enabled to share and identify themselves with others who are going through similar problems.

In the second phase, the feedback from other members will be of help to them to work through denial. In other words, the group process helps its members to clearly understand their own attitudes about chemical dependency and the defenses used by them to protect themselves from giving up chemicals. This is achieved by confronting others with similar attitudes and defenses. All through, care has to be taken to avoid creating any intense anxiety. Necessary precautions should be taken to make the whole group experience, non-threatening to the members.

By the time they enter the third phase, the group experience would have enabled the members to reach a stage wherein they are geared to concentrate on recovery plans. It has been observed that the process of the earlier interactions would by now have led to a spontaneous outcome, whereby more important psychological and social issues like loneliness, depression, problems in sobriety, interpersonal problems, and future plans in recovery are discussed.

Group membership has to be contingent on maintaining abstinence, clients' willingness to struggle honestly with conflicts about continued use of chemicals (or wish to take drugs).

Drug taking and other vagaries of behaviour like discontinuation of antabuse, misuse of medication, irregularity, and tardiness are addressed and explored to the fullest extent possible in the group, if and when they manifest themselves.

In between group sessions, the members also would require support through individual sessions in order to counter shame, guilt, anger and ensure continued participation. Extremely personal and intimate issues can be handled in the 'one-to-one' individual sessions with the counsellor.

Therapeutic benefits

Most chemical dependents seem to possess certain patternised characteristics like low frustration tolerance, inability to endure anxiety, feelings of isolation, low self-esteem, problems in dealing with anger, and memory/cognition deficits. The major defence mechanism used is denial. These characteristics can be effectively handled in the group. Group members provide the warmth and support necessary to help the individual develop trust in others, kindle hope in him that recovery is possible, and build a sense of self-acceptance and self-worth.

The group is able to provide this help through the members sharing their personal experiences of illness and recovery. The problem of isolation is also handled. The members of the group help each other to overcome problems, feel more comfortable with themselves and others.

The above mentioned benefits are achieved through the processes of

— peer identification
— mutual support
— idealisation of those who maintain sobriety.

Role of the counsellor

What are the roles of the counsellor in a group situation?

— To function as a change agent.
— To help other group members provide acceptance, support and hope.
— To provide an opportunity for feedback, testing and learning.
— To maintain a congenial and cohesive climate.
— To handle failure, rejection and other disruptive behaviour.
— To accept certain types of behaviours and attitudes, and to disallow those considered non-productive.
— To keep the group focused on the topic.

Recording

Recording of an individual client's performance has been found to be indispensable. Recording aids in the evaluation of the client's performance and progress. The format for recording that can be followed is given in the appendix. The columns/items in the format are self-explanatory.

To conclude:

★ Group therapy is one of the most recommended techniques in dealing with the various aspects of addiction.

★ The group helps the individual not only to abstain but also to learn to feel comfortable with himself and others.

★ The three important processes are peer identification, mutual support and idealisation of those who maintain sobriety.

Value additions place

— Additional information

Yalom's curative factors*

Curative factors in group therapy have been widely discussed in literature, with the rationale that the isolation of this group of factors would help in formulating systematic guidelines for the tactics and strategy of the therapist.

Yalom (1975) has identified the following as having 'curative value' from the patients' point of view.

1. **Group acceptance** implies 'belongingness' or a warm, friendly, comfortable feeling in the group.
2. **Altruism** involves wanting to do something for others.
3. **Universalization** is realization that the individual is not unique and that there are others with problems either identical or very similar to one's own.
4. **Interpersonal learning — Input** (i.e.) the group teaching the individual, showing how he relates to others, personality defects etc.
5. **Interpersonal learning — Output** using the ability to get along with other people, learning about the way to relate to other group members, etc.
6. **Guidance:** The therapist or other group members suggesting a course of action, advice on how to behave with someone important in one's life, etc.
7. **Catharsis:** Getting things off one's chest; expressing positive and negative feelings towards other group members, the leader etc.
8. **Identification:** Imitating others in the group, both members and the leader; imitating others who are better adjusted in the group.
9. **Family re-enactment:** Resembling, understanding or reexperiencing the individual family.
10. **Insight:** Discovering positive and negative aspects of one's own behaviour which were previously unknown or unacceptable.

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* Reprinted from Bain Donna et al "Counselling skills, For Alcoholism Treatment Services, A literature review and experience survey, Addiction Research Foundation, Toronto, 1979.

11. **Instilling hope:** Inspiration and encouragement received from seeing and knowing that others with problems similar to one's own, have improved.
12. **Existential factors:** Learning that one must take ultimate responsibility for the way one lives regardless of the guidance received, recognising that life is sometimes unfair and unjust etc.

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25
RELAXATION THERAPY

Chemically dependent people often resort to the use of drugs as a means of coping with stress. Therefore, when they come for treatment, it is essential that the counsellor teaches them other methods of handling their stress and tension.

Relaxation is a behaviour therapy technique wherein clients are taught to keep their body and mind calm, as a result of which they will be able to handle situations more effectively.

A relaxation programme **aims** at teaching the client methods to produce the basic relaxation response so that he can eliminate tension from his body and feel a **deep** sense of relaxation. Later on, these relaxation skills can be used by the clients in any situation, anywhere.

The prerequisites for bringing on the relaxation response are the following:

1) A quiet environment
2) A comfortable position
3) A mental device (some thought or object on which to focus one's attention).
4) An 'unruffled' attitude whereby distractions are ignored and attention remains focused on the mental device.

The basic principle in this programme, and its first goal is to teach the client what the opposing feelings of tension and relaxation are really like.

The criteria for relaxation

1. The person should concentrate fully on what he is doing without allowing any other thought to interrupt.
2. He should not fall asleep.
3. Tight clothes should not be worn during relaxation.
4. He should breathe normally without taking a deep breath. Neither should he hold his breath.
5. Concentration should be only on that part of the body which is engaged in tensing and relaxing.

6. There are various steps which involve tensing and relaxing of muscles. The order of steps should not be changed.
7. He should do it as slowly as possible and avoid sudden jerks when he executes the steps.

The Jacobson procedure

Given below are instructions, in verbatim, which the counsellor would give to the clients in person, in individual, or in group sessions. Jacobson was a renowned behaviour therapist who evolved this procedure. His technique has been followed here.

Lie down on your back with palms facing upwards, as comfortably as possible. Close your eyes gently. Now chase away all thoughts coming into your mind. Try to concentrate completely on what you are going to do, so that you can feel the difference between tension and relaxation and thus enjoy the comfort of being relaxed.

RELAX.....

1) Tightly clench your right fist. Feel the tension. Feel how uncomfortable it is when you are tensed. Now slowly relax your fingers. Relax them completely and feel the difference. Feel how comfortable it is when you are relaxed. Enjoy the feeling of being relaxed.
2) Repeat the same procedure with the left fist.
3) Do the same with both fists.
4) Clench both fists. Touch your shoulders with your fist without raising your arms from the floor , **relax**...
5) Press the sides of your body with your open palms (fingers open)...
6) Touch the sides of your body with your open palms and push your shoulders downwards...
7) Touch the sides of your body with your open palms and push your shoulders upwards (towards your ears)...
8) Raise your eyebrows with your eyes closed gently...
9) Knit your eyebrows...
10) Press your eyelids harder (do not shrink them)...
11) Press the upper part (roof) of the mouth with your tongue (the whole tongue and not just the tip of the tongue)...
12) Clench your teeth as hard as possible (press your upper teeth to your lower teeth)...
13) Press your upper lip to your lower lip...

14) Raise your head off the ground and touch your chest with your chin. In the same raised posture, slowly turn your head to the right (as much as possible) then to the left, then slowly to the centre and then slowly relax...

15) Raise your chin upwards as much as possible. In the raised posture slowly turn to your right, then slowly to the left and then bring it to the centre and then slowly relax...

16) Try to bring your shoulders as close as possible, by keeping your arms on the ground (you can feel the tension at the nape of your neck)...

17) Press your shoulders to the ground, so that your chest expands...

18) Push your stomach as far inward as possible...

19) Push your stomach as far outward as possible...

20) Keep your head, arms, waist, legs and feet on the ground and raise just your back off the ground.

21) Tighten your thigh muscles...

22) Bring your feet closer and push them as far inward as possible (towards your face without raising your legs)...

23) Bring your feet closer and push them as far outward as possible...

24) Now slowly take a deep breath and hold it (for few seconds) then slowly breathe out...

Start breathing normally.

Now right from head to toe, each part of your body is relaxed and is as light as a feather. Likewise your mind is also calm and comfortable. Enjoy the comfort of being relaxed.

RELAX.... RELAX....

Be in that relaxed state for about five minutes, each minute enjoying the feeling of being relaxed.

Then slowly count 5, 4, 3, 2, 1 and slowly open your eyes. Slowly turn to your right and lie down and then slowly get up and sit down feeling light and relaxed, both in mind and body.

Guidelines for the therapist

1. Have at least two regular appointments with the client per week for seven weeks. Initially relaxation is taught muscle group-wise. Supervision continues even when muscle groups are completed.

2. Always start with the following order for relaxing of groups of muscles:

Major Group I

a. Dominant hand and forearm
b. Dominant biceps
c. Non-dominant hand and forearm
d. Non-dominant biceps

Major Group II

a. Forehand
b. Cheeks and nose
c. Jaws
d. Lips and tongue
e. Neck and throat

Major Group III

a. Shoulders and upper back
b. Chest
c. Stomach

Major Group IV

a. Thighs and buttocks
b. Calves
c. Feet.

3. You can suggest that your client relax at home for 20 or 25 minutes daily, to get the full benefit of relaxation therapy.

4. To help in scheduling sessions and to keep track of progress, maintenance of Log Sheets would be useful. A sample format is given below:

Name: File number:
Sex:
Age:
Clinical diagnosis:

Date	Session Number	What was practised

5. Simultaneous individual counselling is an essential adjunct to relaxation.
6. Family members may also be taught this technique since they are also anxious. This can be done at the discretion of the therapist.

We are aware that many people look upon drugs as a means by which an individual can cope with stress. It is necessary that the counsellor teaches the client other ways of handling stress and anxiety. Relaxation is one such technique that can be taught.

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26
ASSERTIVENESS TRAINING

Assertiveness is one's ability to act in harmony with one's values and self-esteem, without hurting others.

Assertive behaviour, in practice, is a socially appropriate, interpersonal behaviour, involving a straightforward expression of thoughts and feelings, consistent with one's value system and self-esteem; and at the same time, avoiding hurting others to the greatest extent possible.

When a person conduct himself in an 'assertive' manner, the feelings and welfare of others as well as his own feelings are taken into account. The verb 'assert' means, to state or affirm positively, assuredly, plainly and strongly.

Each one of us can think and act in three different ways:

1. **Assertively:** to stand up for our rights in ways which do not violate the right's of others.
2. **Aggressively:** to stand up for our rights and to express our thoughts, feelings and beliefs in such a way that others' rights are violated.
3. **Passively:** to fail to stand up for our rights, to express our thoughts, feelings and beliefs, or to express them so apologetically that they are ignored.

The characteristic traits which dominate each personality type are given in the following table:

	Passive	Aggressive	Assertive
Behaviour	Doesn't stand up for one's rights.	Stand up for one's rights but violate others' rights.	Stand up for one's own rights in such a way as not to violate others' rights.
	Put oneself down and always apologetic about feelings, needs and opinions.	Put down others, ignore or dismisses feelings, needs and opinions of others. Express oneself in rude ways.	Express needs, opinions and feelings in direct, honest and appropriate ways.

	Passive	Aggressive	Assertive
Attitude	You're okay, I am not okay.	I'm okay, you're not okay.	I'm okay, you're okay.
	Think that others' needs are more important than one's own.	Think that one's needs are more important than others'.	Think that one has one's own rights, others also have theirs.
	Think that only others' have rights.	Think that others don't have rights.	
	Think that only others have something to contribute.	Think that others don't have anything to contribute.	Think that everyone has something to contribute.
Feelings	Feel helpless, frustrated and angry with oneself and resentful towards others.	May feel good because one has won, but feels remorse, guilt and self-hatred because of hurting others.	Feel good about oneself and the way one treats others.
Aim	To avoid conflict pleases others at any expense	To win at any expense to others.	Maintain selfrespect.

People lack assertiveness because of one or more of the following reasons:

- low self-esteem
- fear of rejection
- inadequacy
- guilt

Therefore, behaviour therapists have evolved a therapeutic programme called assertiveness training. **Assertiveness Training** includes therapeutic procedures aimed at increasing the client's ability to engage in assertive behaviour. Behavioural goals include an enhanced ability to express negative feelings (anger, fear, guilt) and positive feelings (joy, love, praise) appropriately.

Increased assertiveness is assumed to benefit the client in two ways. Firstly, it is thought that behaving in an assertive way will instill a greater feeling of well-being in the client.

Secondly, it is assumed that the client will be able to achieve significant social rewards (dignity, respect, recognition) better, and thus obtain more satisfaction from life. In this, the therapist 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 stresses two factors:

1. Identification of the target behaviour that needs changing.
2. Planning a systematic programme with the patient to achieve this result.

Goals of assertiveness training

Assertiveness training should aim at teaching the client the following:

- Everyone has basic rights.
- Each one is responsible for himself and his behaviour.
- It is often easier to bring about a change in oneself than in others.
- When an individual changes his behaviour, others will start responding differently to him.

Technique of assertiveness training

By far the most commonly used technique of assertiveness training is **behavioural rehearsal**. This technique requires the client and the counsellor to act out relevant interpersonal interactions. Part of the time the client plays the role himself, with the counsellor assuming the role of 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 with some degree of realism. The following is the summary of the main points associated with the technique of behavioural rehearsal as it is 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, nonpunitive 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 bountifully rewards (praise, appreciation) improvement. Steps three and four are repeated until both the counsellor and the client are satisfied with their responses, and the client can engage in his response with little or no anxiety.
6. The interaction, if it is 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 and client should make decisions jointly regarding expression of feelings. Here the counsellor should stress on implementing the minimal effective response. This means implementing that behaviour which would ordinarily accomplish the client's goal with a minimum of effort and a very small likelihood of negative consequences.
8. The counsellor may wish to gradually fade out the modelling of assertive responses and have the client assume more and more of the responsibility for generating assertive tactics.

Assertiveness training assumes that small changes in behavioural pattern may bring about a large and wholesome impact. Therefore training is carried out in a hierarchical manner.

In the **first level**, a deficit 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, ask favours and make requests, to communicate feelings and thoughts in an open direct way, to 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

Assertive responses which are to be developed by the client are briefly described here.

Non-verbal

- Making adequate eye contact is most important. The client should learn to look people in the eye.
- Talking in a loud, clear voice, so as to be heard by others.
- Maintaining an adequate, comfortable, erect body posture.
- Using 'facial talk', which involves practising facial expressions that normally go with different emotions.
- Using appropriate natural gestures.

Verbal

- Use 'feeling talk', which involves practice in expressing any feeling literally.
- Practise expressing one's own opinion when others disagree.
- Practise the use of "I" in situations like admitting a mistake or accepting responsibility.
- Practise accepting compliments.
- Practise giving compliments.

Chemical dependency and assertiveness

Feelings of social inadequacy or an inability to express emotions can both contribute to frustration and thus serve as potent cues for drug taking behaviour. Research has shown that the social pressures exerted on chemical dependents, to get them to take chemicals often led to a relapse. This finding has stimulated a number of behaviour therapists to advocate that the chemically dependent should be taught how to say 'no' effectively. A study by Miller and Eisler [4](1977) indicated that alcoholics (when sober) scored low in the ability to express negative feelings such as anger or irritation. They further found that alcoholics who were unable to express their negative feelings subsequently consumed more alcohol than alcoholics who did express their feelings. Thus a correlation was noted between lack of assertiveness and excessive alcohol consumption.

Typically assertiveness training with a chemically dependent can take the following forms. 1) Actual incidents wherein clients had been under tremendous social pressure to consume drugs. 2) Situations where the client needs to convince a party otherwise. These are then used in role playing sessions.

Examples — *Client is attending a party where alcohol is served.*
— *Wife suspecting that the client has consumed drugs.*
— *Wife insisting that she invest in a commodity that the client feels is not of immediate priority.*
— *Boss requesting the client to stay after office hours (overtime) but the client having another important commitment.*

The chemically dependent practises looking straight (eye to eye), varying his voice (tone) and facial expressions where appropriate and confidently articulates appropriate replies.

The evidence pertaining to the efficacy of this therapeutic intervention indicates that chemical dependents are able to modify their habitual way of responding to social pressure and have reported increased feelings of confidence and self-esteem after successfully refusing drugs, using their newly learned skills.

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27
IMPROVING SELF-ESTEEM

Self-esteem can be defined as a positive feeling and respect for oneself. It is essentially a measure of self-worth and importance.

Self-esteem is an important part of the personality that has been shaped from very early years. During childhood, if an individual's feelings are respected, thoughts valued, and abilities recognised, the child's self-esteem gets strengthened. When feelings are trampled upon (''I don't care about what you think/want''), thoughts belittled (''What a lousy idea''), and abilities criticised (''You can never do anything correctly''), the child's self-esteem remains at a low point of development and is therefore weak.

During the course of time, an individual faces many life situations. Depending upon the success or failure and one's reaction to every significant situation in life, self-esteem either grows stronger or gets considerably weakened.

An individual with a **strong self-esteem** is able to act towards others in non-threatening ways, build healthy relationships and finds himself successful. He is confident, dynamic, appreciative, achievement oriented, contented and open to change.

An individual with a **weak self-esteem** has a negative self-image and poor self-concept. These come in the way of his ability to build relationships, and to be successful. He is critical, self-centred, cynical and diffident.

Some individuals who have a low self-esteem, may try to project themselves as persons with adequate self-esteem. These individuals usually talk in superlatives, are over-confident and make unrealistic statements.

Self-esteem and addiction

One of the ''pre-disposition theories'' of drug addiction points out that an addict has a low self-esteem, which manifests itself in the following ways:

Self-centred

The individual gives importance only to his own feelings, likes and dislikes. He is not willing to consider the feelings and needs of others. This self-centredness alienates him from others.

Critical

The person makes critical judgements about others' behaviour in order to cover up his own mistakes. Nothing seems to satisfy his expectations and minor slips are singled out for severe condemnation.

Cynical

The individual firmly believes that everyone is unjust; he is ready to believe the worst of others. He carries a huge load of past resentments based on real or imagined injustices. He misinterprets others' thoughts and actions and makes himself and others miserable.

Diffident

The individual starts thinking that nobody cares about him. He suffers from feelings of self-doubt and insecurity. He sees even small failures as proof of his inadequacy. Even if he has abilities, he fails to utilize them because he is convinced that he will fail.

Guidelines to improve the self-esteem of the chemically dependent

Developing a strong self-esteem is of crucial importance in the chemically dependent's recovery. He should be reassured that self-esteem is a quality that can be strengthened at any point in his lifetime.

The client should keep in mind that building up self-esteem is a slow process which requires patience and perseverance.

The counsellor may give the following guidelines to the chemically dependent which will help him to strengthen his self-esteem. These tips are practical and easy to follow.

Give positive strokes generously

Appreciation through words, facial expressions and gestures are termed positive strokes. Positive strokes help increase self-esteem of both the recipient and the giver. Giving positive strokes is a healthy exercise and calls for recognition of worth in other people. When an individual treats other people with dignity, respect and love, his own self-esteem automatically grows stronger. It helps him learn to recognise merits in the actions of people around and express appreciation explicitly.

> *Muthu's son had won a prize in a drawing competition. Muthu took great pride in relating this to all his colleagues the very next day. Surprisingly, he did not say a word of appreciation to his son.*

Muthu felt proud about his son, but never voiced his feelings openly to him. A positive stroke expressed explicitly and directly, surely helps to strengthen the relationship and build self-esteem.

Avoid plastic strokes

Compliments which are excessive or not genuine, can be referred to as "plastic strokes". Like counterfeit money, which has no market value, fabricated compliments do nothing to improve the self-esteem of the giver or the receiver. This dishonest 'underhand exercise' harms the giver as he loses the ability to pay honest compliments.

Receive positive strokes gracefully

The client should be taught to receive positive strokes with grace. Many people feel uncomfortable while receiving positive strokes. Refusal to accept them, is a serious drawback in character that discounts feelings of self-worth.

Positive strokes are necessary for us to maintain a strong self-esteem. They are as necessary as water is for plants. Positive strokes are extremely vital for emotional wellbeing. Positive strokes are invaluable gifts given to us in recognition of our worth. They need to be treated as such and accepted gracefully. Refusal to accept them, is as ludicrous as throwing away a priceless gift.

> *Kumar's manager said, "You have done an excellent job of the brochure." Kumar responded saying, "Well! frankly speaking, I am not totally satisfied with the outcome. I feel I could have improved upon the cover page. I hope that the Chairman will like it."*
>
> *Kumar could have been more gracious in receiving the compliment by saying*
>
> *"Thank you for your encouragement, sir. I am happy that the extra efforts I had put in have proved valuable."*

In the above example, positive strokes have been examined with suspicion and found to be wanting. Such an approach prevents an individual from utilising these positive strokes towards the development of a healthy personality.

Even a person with a strong self-esteem may experience periods of uncertainty. During such moments, sharing one's feelings with someone who is empathetic and compassionate will help in strengthening self-esteem.

Reject unconditional negative strokes

Unconditional negative strokes are those generalised, all encompassing, negatively toned statements. Though these statements lack any factual basis, they are capable of causing havoc to the self-esteem of the recipient.

The recipient is often aware that the statement is not fully true. But he ponders over it and asks himself "How can they say that about me?", and wallows in self-pity.

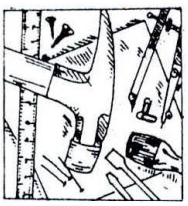
Praveen's father told him, "You pretend as though you are not taking brown sugar. You have undergone treatment, and therefore, are making a big show of it. You can never be disciplined. Even now, I am afraid you must be taking drugs at night without our knowledge!"

Unconditional negative strokes mess up an individual's self-esteem. They make one feel less worthy. Therefore, when an unconditional negative stroke is given, one has to exercise his right to reject (and not react to) it.

The following four steps may be practised.

— Compliment people directly and explicitly and experience a warm feeling.
— Shun flattery.
— Receive genuine compliments with confidence and grace.
— Ignore unconditional negative strokes, and stay balanced, secure and comfortable.

Value additions place

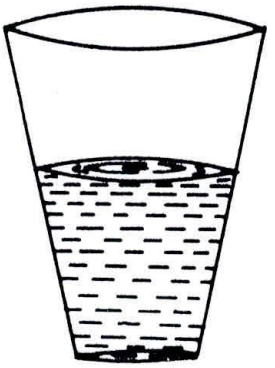


— Implementation tool

Games are an effective modality through which the self-esteem of the client can be improved.

Game I

The participants are a group of clients or a client with his family members. One member sits in front of the group and all the other members express the positive qualities of that person. Eye contact is maintained while giving the positive stroke. Members should compulsorily use the terms, "I feel" and "You are" while talking. Some people may say that they do not see any positive qualities in the other person. In such instances, the group may be given an exercise. They may be asked to see the figure drawn below:



This figure will be seen as a half-full tumbler by some and a half-empty tumbler by others. Just like the fact that some people see only the empty half, there are some people who choose to see nothing worth complementing in others. In other words, what one sees in others, depends on what he chooses to see or not to see in himself. At least with efforts, one can definitely see some good in each individual. This is the message the counsellor should convey to the group.

Game II

This is an assignment. A group of clients are asked to write down whatever they feel about the following:

1. Five positive qualities of your personality.
2. Three things you are really good at.
3. Some words you would like people to use when they talk about you.
4. Three special things you have learnt from people in your family.
5. Three things about yourself which you would like to change so that you become a better person.

After the group has answered, they can be divided into smaller groups of 4 or 5 and can share whatever they have written. Sharing of positive thoughts and good feelings will contribute towards strengthening the self-esteem of each participant.

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28

MARITAL COUNSELLING

Much attention has been focussed in recent years on understanding chemical dependency, the chemically dependent and his family. This is vitally important, as it calls for recovery of the family along with the chemically dependent. Apart from paying attention to family relationships at large, counsellors need to handle the various issues which are at conflict in the marital relationship.

Understanding chemical dependency *per se* is the issue which should be first addressed. The wife might have never known that her husband used alcohol/drugs, or might be alarmed at the excessiveness of its use. In our culture, where the use of chemicals is still largely unacceptable, this may also induce fear and mistrust in the wife. The progressive dependency brings about a number of negative personality traits in the chemically dependent person which further erode the foundation of the marital relationship. Some of these traits are immaturity, intolerance, increased sensitiveness, or irritability at times even leading to verbal or physical abuse, disturbed interpersonal relationships, low self-esteem, grandiosity (extravagance) and irresponsibility.

The wife in turn develops her own set of patterned responses. Initially, she is confused, scared and unable to comprehend the negative consequences that will follow. But as the dependency progresses, she tends to get over protective. Embarrassment and shame drive her to hide his lapses, or tell lies. She also experiences hurt and guilt when she tries to explore whether she could be the cause. As the damages increase, anger and hate become predominant. Eventually, there is a feeling of hopelessness which leads to a total indifference, or a resentful rebellion which leads her to think of separation. In order to cope with problems, the wife makes several attempts to control or put an end to the dependency; but seldom succeeds.

This leads to a progressive deterioration in the marital relationship. Communication between partners becomes minimal and this leads to further misunderstanding and baseless assumptions about each other.

The non-dependent wife often takes over the responsibility of running the family, making decisions, and at times, taking the role of a bread-winner too. This unhealthy state of the marital relationship requires a lot of attention, so that the damages in the relationship are rectified and changes brought about for the better.

And hence, the need for marital counselling. A trained unbiassed counsellor could help the couple reflect on their past and present disturbances and work out changes for the better. Marital counselling is actually the handling of marital conflicts by a qualified person.

The use of therapeutic relationship in helping the partners develop an understanding of themselves and their problems, is of prime importance.

Guidelines for marital counselling

- ★ The counsellor needs to first develop a mutual trusting relationship with the couple.
- ★ The couple's motivation for change needs to be assessed.
- ★ The couple need to be assisted in identifying problem behaviours/areas.
- ★ Factors that initiate and maintain these behaviours need to be identified.
- ★ The counsellor also needs to be as specific as possible in his identification of problem behaviour and planning of remedial strategies. This is to avoid any confusion or use of manipulation on the part of either partners.
- ★ Appropriate behaviours to substitute problem behaviours need to be selected by the mutual consent of the couple.

The primary objective prior to specific marital counselling is the need for assessment by the counsellor of the wife's understanding of the problems created by chemical dependency.

This means assessing the acceptance level of wife, — whether she is able to accept the chemically dependent from the disease angle — and giving her proper education wherever necessary. This is essential because inadequate understanding can prove a continuous block to counselling while specific marital problems are addressed.

Some spouses take on a sympathetic attitude, — are understanding and open to change — in their husband's recovery. Some others become hostile and vehemently resentful and blame each other for their disturbed marriage. A few are indifferent and even unwilling to continue their relationship. With education and clarification, most of the problems can often be sorted out. In some cases, temporary or permanent separation might be found a better alternative, during which time individual counselling for each partner needs to be pursued.

With regard to the issue of meeting the couple individually or together, (conjoint) it is often found advantageous to meet them separately in the beginning, so as to avoid open disagreement at the very outset. Often the partners themselves make a request to be seen separately. Once information has been gathered and problem areas sorted out, conjoint sessions can be held. With experience, a counsellor can use his discretion in planning individual/joint sessions.

In addition to the above, two important skills have to be mastered by the couple:

— communication skills

— problem solving skills

By and large, these are the aspects which have been considerably damaged in the marital relationship.

Communication skills

Marital satisfaction can be greatly enhanced by altering their style of interaction. Here the counsellor monitors the way of communication while the husband and wife attempt problem solving. The counsellor intervenes when there are destructive interactions, and guides them through ways to improve their communication. A specific and direct approach is often necessary to stop problematic communications.

Given below are the disruptive (Don'ts) and facilitative (Do's) communications. Couples could be briefed regarding these before the session.

Disruptive communications (Don'ts)

1. Interrupting: Interruptions may occur when a partner is actively talking and when he or she has paused for a moment. This behaviour should be brought to their notice.

Husband: "Well, I have understood the harmful effect of chemicals. I will definitely..."

Wife: "You will not, you have promised this several times before."

Counsellor: "Keep away from interruptions because they frustrate your partner and make him feel that you are not listening well. Listen and wait for him to finish."

2. Blaming each other: Often partners blame each other and try to decide who is at fault. The counsellor should teach the couple other ways of handling the situation.

Husband: "You shouldn't have yelled at me when I was late."

Wife: "Well, I wouldn't have if you had been on time."

Counsellor: "You are trying to decide who is at fault. People become angry when they are blamed, and it will prevent you from working together. Don't argue about whose fault it is. Look for ways to handle the emotions/situations that will satisfy both of you.

3. Trying to establish the truth: Often couples have different views regarding how an event happened, and would try to convince the other partner that they are right. The counsellor would have to intervene in such a situation.

Wife: "You did not take your antabuse today."

Husband: "I did take it. You were busy...."

Counsellor: "Both of you seem to have different views of how it happened. Arguing over the truth of specific details won't help you solve the problem, instead it may make you both angry."

4. Getting sidetracked: While discussing a particular problem, one spouse may divert the conversation from the problem. Couples should learn to tackle only the issue being discussed.

Wife: "You are very irritable. You are not taking antabuse regularly."

Husband: "Nobody is listening to me when I talk about your mother's property. She is also refusing to come and stay with us."

Counsellor: "You are getting sidetracked. Remember to stay on one issue at a time. Other issues may seem related, but they get you off the track."

5. Dealing with multifaceted problems: Couple should learn to tackle one issue at a time.

Wife: "He is angry with my father for meeting his boss and refuses to go back to the office. He did not have lunch today. He also wants to start business right away."

Counsellor: "You are talking about too many problems. It is often confusing to deal with many aspects of a large problem — all at one time. It is best to choose one part to work on."

6. Making the other person feel guilty: One spouse may often try to make the other partner feel guilty.

Wife: "You just don't care about my feelings. You insult me all the time; you are not bothered as to whether I live or die."

Counsellor: "When you say that, — whether you mean it or not, — it implies that the other person is horrible and insensitive. This may make the person feel guilty and angry and he may shout back at you. Avoid using guilt producing statements."

7. Making improper moves and giving ultimatums: Spouses often tend to give ultimatums to each other.

Wife: "If you drink again, I'll leave you, or commit suicide."

Counsellor: " You just gave your husband an ultimatum. Ultimatums push people into a corner because they either have to lose face by giving in, or act tough and tell you to go ahead. Either way they become more resentful, and the problem will not get solved."

8. Using the words 'always' and 'never': Couples would tend to use words like "always" and "never" that have a sweeping impact.

Wife: "You are always late."

Husband: "Not at all. Last Friday I reached home at 5 p.m. I have definitely been more punctual than before."

Counsellor: "Avoid using the words "always" and "never". They only lead to useless arguments. It also conveys that you do not believe he would change and you are not willing to notice any change for the better!"

9. Accusing the partner by labelling him: Spouses at times tend to 'label' their partners.

Wife: "You are an arrogant fellow."

Counsellor: "You have just called your husband a 'name', and that may make him angry. When you label your husband, you imply that he cannot change. Instead, you can tell him the specific behaviour you dislike in him.

10. Mind reading: Spouses tend to assume what their partner is thinking and express their assumptions emphatically.

Wife: "I know that you think I have taken money from your purse."

Counsellor: "You just told your husband as to what he is thinking, as if you could read his mind. Your judgement can be wrong, and even if you are right, it can make him angry. If you want to know what your partner thinks, just ask him."

11. Discrepant verbal and non-verbal communications: Quite often there may be discrepancies between one's verbal and non-verbal communications.

Husband: "Okay, if that is what you want..." (sighs and rolls eyes)

Counsellor: "Verbally you have agreed, but your gestures clearly show that you are not agreeing."

Supportive communications (Do's)

A list of common skills which are useful for a couple to learn is presented below:

1. Talking to each other

In the therapy session, whenever possible the partners can be encouraged to talk to each other and not to the counsellor. This has to be done especially while discussing specific issues or when conveying changes in behaviour or attitude. This emphasis also helps in eliminating the tendency of many partners to draw the counsellor onto "their side" against their mate.

2. Making eye contact

Eye contact is encouraged because it can form a psychological bond which helps the partners to work together as a team. Averted eyes may indicate a distracted or disinterested partner, and this may lead to resentful feelings.

3. Making personal statements

These statements usually take the form of "I feel..." or "I think..." and take the place of statements which speak about or for the partner, starting with "you feel..." or "you think..." These statements provide direct information about the person's own feelings and encourage the partners to take responsibility for their behaviour and feelings.

4. Practising reflective listening

Reflective listening shows that the partner is listening to and understanding what the speaker says, rather than implying that he is daydreaming or planning a confrontation. This skill is especially helpful for couples who frequently interrupt each other because it slows their pace of interaction and teaches them to listen to each other.

5. Giving encouragement

In order to change the couple's negative reinforcement schedule to a positive one, couples should be encouraged to give positive reinforcement directly. They should be encouraged to tell each other what they like about the partner, where the partner has been doing well and suggestions of the partner that have proved helpful.

6. Attending behaviour

Nodding the head is an indication of good listening because it is a non-verbal way of communicating to the speaker that his message is being received.

7. Stating what one likes or needs

During the course of problem-solving the counsellor provides a safe situation in which partners may honestly state what they like and need. Thus, they can be encouraged to be open about their needs.

Problem solving skills

Another major characteristic of many troubled marriages is an inability to solve problem. Counsellors could teach the couple specific problem solving steps. This would consist of the following steps:

Selecting and stating a problem

During the initial stages of therapy, most couples use vague, emotional words while stating their problems. This is because they often see the partner with a different understanding of the problem and always with feelings of blame, resentment and guilt. Counsellors need to teach them to use specific, descriptive terms about the partner's behaviour when stating problems.

Another common difficulty is that couples often want to work on large, emotionally laden problems early in therapy. However, the initial sessions of therapy should focus on relatively small, non-threatening problems for two reasons. First, the focus of the early sessions is teaching problem solving techniques and communication skills. When couples deal with major problems they are likely to concentrate on the content of the problem instead of on the development of skills. Secondly, until they become proficient with their new skills, couples will not be able to resolve their large emotionally laden issues.

Listing possible alternatives

Once a couple has selected an appropriate problem and stated it specifically, the second step — stating alternative solutions — begins. Couples have a "brainstorming" session and a list of unevaluated alternatives are obtained. Next, they pick up one alternative at a time, evaluate it and discard, if it is unacceptable. The preferable choice is then consciously made.

Agreeing on a final solution

This involves the couple choosing the best alternative (as the solution) which they agree to implement. This alternative must be acceptable to both the partners.

Evaluation

It is essential that the couple review their choice of the best alternative and evaluate if it has helped them in tackling the problem. This should be done honestly and openly. If they find that the chosen solution has not been helpful, they should go back to the first step.

E.g. A couple who has been separated due to "drinking problems" comes together during treatment. The husband feels confident about his abstinence and wants to bring his family over to live with him again. But he does not have a house to stay in, has lots of debts and is not in a position to ensure security for his family. His wife expresses these difficulties, and suggests that they get together after a year, by which time things would have settled down. They 'discuss' problems which may crop up if he continues to stay alone immediately after discharge — problems like loneliness, food and isolation. They also discuss problems that may arise if they live together immediately — adjustment problems, finance, house, children's school, etc., and decide on the better alternative. They also arrive at possible solutions to problems anticipated in the alternative selected. Finally, they evaluate the decision taken.

No marital counselling would be complete without handling of sexual problems. Often addiction to chemicals leads to disharmony in sexual relations also.

The major sexual problems in the male are:

1. Decreased sexual urge or desire or lack of inclination.
2. Premature ejaculation : Dysfunction where ejaculation takes place even before full penetration.

3. Secondary impotency (Erective dysfunction) : Sustained inability to maintain an erection due to psychological causes which will allow normal heterosexual penetration and ejaculation to take place.

4. Desire to continue a long-standing pre-marital/extramarital relationship.

These need to be looked for in all clients and discussed. Appropriate referral to a sex counsellor can be made. In the case of a desire to continue a long standing pre-marital/extramarital relationship it needs to be emphasised that such a relationship and sobriety would not go together and the client would need to get his priorities clear.

The spouse (female) may also manifest problems in the form of:

1. Disinterest, decreased desire or lack of inclination.

2. Frigidity : Dislike of or aversion to sexual intercourse of psychological origin of sufficient intensity to lead, if not to active avoidance, to marked anxiety, discomfort or pain when normal sexual intercourse takes place.

The counsellor needs to explore this as a factor in sexual maladjustment.

Often with recovery in other spheres namely, physical, occupational, interpersonal, financial and mental the sexual problems also return to normal.

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FINANCIAL MANAGEMENT

After an addict is treated, several problems which were earlier secondary to the problem of addiction, come to his notice. Financial mismanagement, particularly non-repayment of debts is one such problem which the treated chemically dependent encounters. Repayment of debts creates an enormous amount of stress on the addict and therefore it is a condition that warrants attention from the counsellor. In the past, the client would have used the problem of debts as an excuse, to continue drug taking. Possibly on several occasions the wife or other family members would have cleared the debts, with the belief that once the debts are repayed, the client would stop taking chemicals. This behaviour of the family is known as **Enabling**. While counselling, the counsellor should not **enable** the client, but help him to make realistic plans, and guide the client to take the necessary initiative and carry out his own responsibilities.

Financial problems come under two broad heads:

1. Repayment of debts
2. Living within the available income

Repayment of debts

Dimensions of the problem

— Individuals tend to borrow from several sources like friends, relatives, Pawn Brokers, Loan Sharks etc. For a small sum of money, say Rs. 1,000, the client may have to face many (5 or 6) money-lenders. No matter what the due amount is, answering a lender poses a problem to the borrower.

— Loans from Pawn Brokers and Loan Sharks, who advance money without security, carry exorbitant rates of interest. Because of the high rates of interest, whatever the borrower manages to pay will cover, at best, only the interest, and the principal liability would continue to remain forever. Sooner or later, the borrower gives up the hope of ever getting out of his problem of debts.

— Acquiring objects: There may be a tendency to buy costly articles like T.V., fridge, grinder, mixie, etc which they consider essential for the house. But this would involve a sudden burden on the family budget. Therefore the family members should be told to postpone it.

— Pilgrimages: After discharge, the whole family plan elaborate pilgrimages. This is a sensitive, sentimental issue, but at the same time it will bring pressure on the existing financial status.

— Impulsive buying: This involves buying unnecessary things — for example, buying fruits everyday, buying expensive clothes or buying whatever one sees.

The family will justify their position. So these problems have to be handled with great care. They will feel that they are all changing, and therefore celebrating it by spending a little money is not wrong. The counsellor should intervene cautiously so that the family does not feel uncomfortable.

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PROBLEMS PRESENTED BY THE CHEMICALLY DEPENDENT CLIENTS

Apart from the problems already discussed in other chapters, there are three important issues which the counsellor will be required to tackle in the treatment of chemically dependent people:

1. Refusal to accept medication
2. Clients coming for counselling in an intoxicated state
3. Acute depression experienced by clients leading to suicidal thoughts and tendencies.

Refusal to accept medication

In the initial phase of recovery, chemically dependent people would have been asked to take antabuse or other anti-depressant drugs. Some of the alcoholics will refuse to take antabuse mainly because they harbour wrong ideas about the possible damages likely to be caused by the medicine. They will also be deeply afraid about the possibility of their having an acute craving for alcohol, in which case they cannot resist drinking. As they know that alcohol and antabuse taken together will lead to severe problems, they will find it easier to refuse to take antabuse. So they will start giving all sorts of excuses.

"I have the willpower to stop drinking; I do not need any medication for that."

"I do not want to depend on pills and evade my personal responsibility."

At this juncture, the counsellor should not force the client to take antabuse. Instead he should investigate and find out the reasons for his refusal through supportive non-threatening ways. He should aim at removing his fear. At the same time, the counsellor should not forget to provide information to the client regarding the effects of antabuse if taken along with alcohol. The counsellor should evaluate and establish a contract instead (i.e.) if the client has a relapse, then he would definitely take antabuse.

The clients may refuse to not only take antabuse, but also the antidepressants prescribed by the doctor. They may be afraid that anti-depressants will have a sedative effect and this will come in the way of their occupational performance. The duty of the counsellor is to educate them about their **need** to take the prescribed medicine and should concentrate on removing their ill founded fears.

Clients arriving for counselling in an intoxicated state

The arrival of clients for their appointment in an intoxicated state is infrequent; nevertheless it does happen and the counsellor should know how to handle the situation.

Under no circumstance should the counsellor threaten him or drive him away. He should accept him but at the same time be firm. He should give him another date of appointment and ask him to come for counselling on that day without using any chemicals. If the client is non-aggressive, he could be told that **no counselling** can be done when he is intoxicated. If the client is aggressive, the counsellor should be cautious. He should have the door of his room open. The client is likely to blame the counsellor for his relapse. He will try to provoke him in every possible manner. At this point in time, the counsellor should be extremely calm and allow the client to 'blow off steam'. He should be careful not to disagree or argue with the client. The client should be told in a firm and understanding manner that counselling is not possible in such a state. He should be sent away as early as possible. The client can be reassured that when he returns sober, he will be taken up for therapy.

Suicidal thoughts and tendencies

On mental status examination, chemically dependent clients have been found to be depressed. Depression is characterised by a pervasive mood of sadness, decreased appetite, decreased sleep, crying spells, suicidal ideation and lack of interest in activities. It is essential to differentiate between neurotic depression (a type of neuroses) and endogenous depression (a type of psychoses) as this has major implications for treatment.

Neurotic behaviour	Psychotic behaviour
Precipitated by a life event. (loss of a loved one, loss in business)	Usually not precipitated by a life event. Occurs even when there is no crisis.
Depression is worse in the evening.	Depression is worse in the morning.
Psycho-motor activity (PMA) minimally decreased.	Psycho-motor activity (PMA) markedly decreased to the extent of stupor.
Personal hygiene not neglected to a significant extent.	Personal hygiene neglected.
No distinctive qualitative change of mood.	Distinctive qualitative change of mood. (I have never felt so sad in my life before.)
Initial isomnia (difficulty in falling asleep).	Terminal insomnia (early morning awakening).

These clients should be sent to the psychiatrists; they may be given anti-depressants along with supportive counselling.

Assessing suicidal risk

For any client who is found to be depressed, an assessment of suicidal risk is essential. Approximately 30% of all those who attempt suicide are chemical dependents.

Certain behaviours suggest the possibility of increased risk.

1. A history of previous suicidal behaviour, especially while under the influence of chemicals.
2. Any family history of suicide.
3. References to feelings of futility such as 'I don't care whether I live or die', or 'life isn't worth living'.
4. Preoccupation with dying and direct references to suicide such as 'I have thought about death a lot lately', or 'sometimes I feel that I would like to kill myself'.
5. Reports of increased depression while taking chemicals or during abstinence.
6. Recent crisis or loss.
7. Severely depressed clients will not have energy even to get up. When they take anti-depressants, the psycho-motor activity will improve, but immediately depression will not be lifted completely. The physical energy coupled with acute depression may give them the strength to attempt suicide.

If two or more of the above indicators are present, intervention will be necessary.

What should the counsellor do?

1. If the client appears to have suicidal tendencies, he should be directed to psychiatric units.
2. After necessary medical intervention, the counsellor should adopt a calm, empathetic and reassuring approach.
3. The counsellor should also involve the family members in the treatment programme. They have to be counselled to keep a close watch on the client; not to leave him alone; not to leave sharp objects around. They should be instructed not to store lethal chemicals.
4. The client, after attempting suicide, would be emotionally unstable. He would feel guilty, ashamed, angry and would often blame himself. This emotional turmoil could drive him to attempt suicide again. Thus preventive counselling, using supportive and reassuring techniques is important. The counsellor should initiate a discussion of the client's behaviour and feelings, in an empathetic manner.
5. The counsellor should not feel guilty and preoccupied with the question "Where did I go wrong?". He must set aside self-condemnation and should not take on the role of the 'saviour' or 'rescuer'.

To conclude,

Treatment of chemical dependency is a rather complex proposition. The outcome or result of this treatment cannot be measured through the traditional criteria like — 'So many were treated, so many became okay and so many did not'. We have to be fully aware of the fact that chemical dependency sets in over a period of time. So, recovery is also essentially a 'process'.

The real challenge lies in understanding the full dimension of this complex problem. It is here that the therapist finds enormous scope to apply his superior knowledge and his 'fine tuned' skill as a counsellor.

As this awareness gets internalised, the counsellor finds the whole process challenging and gratifying.

Patients who recover express their deep felt gratitude, because for them, it is the counsellor who has brought them 'out of the rut'. He has given them a 'rebirth'. Even problem patients, instead of becoming objects of frustration, turn out to be individuals who deserve more empathy and understanding.

From then onwards, it becomes

Professionally satisfying; Personally gratifying.

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Appendix I

MEDICAL HISTORY

Name: Age: Sex:

Address:

Drugs Abused	Prescribed	Non-Prescribed
1) Depressants		
— Minor Tranquillisers		
— Hypnotics		
2) Narcotic Analgesics — Opiates		
3) Cannabis — Ganja		
4) Stimulants		
5) Hallucinogens		

Brief History

Physical Examination:

I. General Appearance
   - Temperature, Pulse, Respiration
   - Skin colour or Eruptions
   - Oedema
   - Body Hair
   - Deformities
   - Pupils
   - Needle marks

II. Respiratory system

III. Cardiovascular system

IV. Abdomen

V. Central Nervous System

Laboratory Investigations:
   - Blood
   - Urine
   - Stool

WITHDRAWAL SYMPTOMS

I. Depressants —
1) Tremors
2) Insomnia
3) Anxiety
4) Depression
5) Restlessness
6) Loss of appetite
7) Loss of memory
8) Withdrawal fits
9) Delirium

II. Narcotic Analgesics —
1) Tremors
2) Nausea, vomiting, diarrhoea, abdominal pain
3) Excessive lacrimation, rhinorrhoea, yawning, sweating
4) Goose flesh (cold turkey), muscle jerks
5) Headaches, bodyaches, etc.
6) Blurred vision
7) Hallucinations
8) Delirious state

III. Stimulants —
1) Tremors
2) Loss of appetite
3) Disturbed sleep and lethargy
4) Fatigue
5) Irritability
6) Depression

IV. Cannabis —
1) Anxiety and nervousness
2) Sleep disturbances
3) Loss of appetite
4) Burning sensation in the chest

IV. Hallucinogens —
1) Hallucinations
2) Tremors
3) Anxiety
4) Depression and restlessness

Appendix II

IN-TAKE FORM

Full Name in BLOCK LETTERS

Registration No.

Date of Discharge from the centre

Date of Registration:

At the Detox Centre:

At the Therapy Centre:

Reasons for discharge:

1) Completed treatment
2) Left with advice of centre
3) Left against advice of centre
4) Referred
5) Hospitalised
6) Dropped out

Sex	Age	Date of Birth	Nationality	Religion/ community	Education

Permanent Address: Phone:

Temporary Residential Address: Phone:

Address of a Responsible Person: Phone:

Urban/Rural	Mother Tongue	Other Languages Known

Marital Status	1) Single 2) Married 3) Widow/er	4) Divorced 5) Separated

Occupational Status	1) Employed Full-time 2) Employed Part-time 3) Not employed 4) Retired 5) Student

Occupation	1) Unskilled/Semi-skilled 2) Skilled 3) Clerical 4) Executive Specify	5) Business 6) Professional 7) Agricultural 8) Defence Service

Place of Employment and address	Phone:	Income per month

Place of prior Alcoholism/Addiction Treatment	Date:

Whether detoxified (Currently)	Place	Date/Duration

Source of Referral	1) Self 2) Spouse/Family 3) Friend 4) Physician 5) Psychiatrist	6) Specialist 7) Employer 8) Hospital 9) Recovering addict

Background information

1. Details of Parents:

   Father's age: Alive/Dead Occupation:
   Mother's age: Alive/Dead Occupation:

2. In case of death of parents:
   a) Not applicable
   b) Your age at father's death.....
   c) Your age at mother's death.....

3. Details of siblings (in the order of birth)

Relationship	Age	Education	Occupation	Marital Status

4. Order of birth.....

5. Current Living arrangements:
   a) Resides in family units (parents/spouse/siblings/children)
   b) Living with friends or distant relatives
   c) Living alone (own place, apartment, lodge)
   d) Institutional arrangements
   e) Transient

Details of drug-taking

6. Circle appropriate number that reflects your use. Specify the drug.
   1) Never used
   2) Have used in the past
   3) Have used in the past and it caused problems
   4) Now using
   5) Now using and is causing problems

Heroin	1	2	3	4	5
Opium	1	2	3	4	5
Morphine/Pethidine etc	1	2	3	4	5
Stimulants, dexadrine, Vitalin	1	2	3	4	5
Ganja, hashish	1	2	3	4	5
Hallucinogens	1	2	3	4	5
Alcohol	1	2	3	4	5
Tranquillisers, sleeping pills	1	2	3	4	5
Tobacco	1	2	3	4	5

7. Pattern of Use:

Type of Drug	How taken?	How often?	How much?	For how long?

8. How old were you when you first took drugs?.....

9. In what context?.....

10. Do you particularly use one type of drug or do you use two or more types? Do you use them in combination?.....
.....

11. Usual intensity of drug-taking:
    a) Take drugs beyond intoxication into a day or more of binge type drug-taking
    b) Usually stops drug-taking when intoxicated
    c) Usually stops short of intoxication

12. Usual compulsivity for drug-taking:
    a) Have compulsive episodes of binge type drug-taking lasting more than a day
    b) Have compulsive episodes of drug-taking to intoxication although not binges
    c) Feel a compulsion to continue although you can still limit your drug-taking
    d) Limit drug-taking at will: no compulsivity experienced.

13. Do you need more or less quantity of drugs to achieve the same effect as you experienced when you started using?
.....
.....

14. The morning after an evening of using drugs, have you ever had the experience of not being able to remember everything that happened the night before? Please give an example.
.....
.....

15. Has anyone ever told you about things you did or things that happened while you were under the influence of drugs that you could not remember? Explain.
.....
.....

16. Have you ever experienced shakiness or hand tremors, sweating, hallucinations, running nose, cramps, watering of eyes? Explain.
.....
.....

17. Has a doctor ever told you to cut down, or stop your drug use for any reason? Explain.
.....
.....

18. Have you ever been hospitalised or sought help because of drug-taking or for complications arising from drug use? Explain.
.....
.....

19. Have you ever sought any prior help for drug addiction? List when and where.
.....
.....

20. Have you ever been to a meeting of AA/NA?
.....
.....

21. Have you ever made attempts on your own to cut down, or stop your use of drugs? Explain.
.....
.....

22. Do you make sure drugs are readily available? Do you stock up? Explain.
.....
.....

23. Does the thought of using drugs sometimes enter your mind when perhaps you should be thinking of something else?
.....
.....

24. Do you ever look forward to the end of a day or the end of a week so that you can use some drugs? Explain.
.....
.....

25. Do you ever use drugs to reduce tension/or relieve negative fellings? Explain.
.....
.....

26. Do you find it difficult to enjoy social events if there are no drugs or drinks?
.....
.....

27. Do you ever use drugs to relieve physical discomfort or treat any illness? Explain.
.....
.....

28. What is your behaviour like when you are using alcohol or other drugs? Are you more funny, talkative, angry, verbally or physically abusive, prone to being abused? Explain.
.....
.....

29. Have you ever got into physical or verbal fights when you are on drugs? Give example.
.....
.....

30. Have you ever compromised or broken your values when under the influence of drugs?
.....
.....

31. Have your family members ever complained or commented about your use of drugs? Explain.
.....
.....

32. While on drugs do you ever get the thought of killing yourself? Have you ever attempted to kill yourself while using drugs? Explain.
.....
.....

33. Have you had any motor vehicle accidents while on drugs?
.....
.....

34. Have you ever sustained physical injury as a result of drug-taking?
.....
.....

Health scale

35. Present health status (before detox)
    a) Health is poor, life is hampered by what are or what is regarded as illness.
    b) Health is fair, manages to get along despite illness or what is regarded as illnesses.
    c) Health is good, with certain conditional comments.
    d) Describes health as unconditionally good.

36. Status of medical treatment
    a) Had either in-patient or out-patient treatment for what, where?
    .....
    b) Felt treatment was required, but did not obtain needed treatment. Why?
    c) Has not required any in or out-patient medical treatment for any illness in the past year (including minor bruises, colds, cuts)

37. Non specific complaints
    a) None reported
    b) Present
    — Changes in physical appearance
    — Loss of weight
    — Anxiety, tension, nervousness
    — Loss of energy, fatigue, tiredness
    — Digestive difficulties
    — Sleeping difficulties
    — Disorders of appetite
    — Headache
    — Others

38. Have you ever had help from Counsellors, psychiatrists, psychologists etc., regarding personal problems? Give details.
.....
.....

Financial status

39. Describe your sources of income
    a) None
    b) By employment
    c) By business
    d) By shares/investment
    e) By rents
    f) By agriculture

40. Do you (or your family) have any assets?
    a) No
    b) Yes, agricultural plots
    c) Yes, houses/buildings
    d) Yes, jewels

41. Does anyone make financial contributions to you or to your family? Mention here if you are a dependant.
    a) No
    b) Yes

42. In the past one year, what percentage of your family's expenses was met by you?
    a) None
    b) About 25%
    c) About 50%
    d) About 75%
    e) 100%

43. Have you incurred any debts in the past one year? Give details.
    a) No
    b) Yes, about .....

44. Have you sold any property, article, jewels, etc? Give details.
    a) No
    b) Yes, worth .....

45. Have you resorted to drug peddling in order to generate funds (earn an income)? Explain.
    .....
    .....
    .....

46. Have you ever been involved in gambling anytime and lost large sums of money? Explain.
    .....
    .....
    .....

Vocational functioning/employment/school

47. How far did you go with your schooling? .....
(if illiterate, skip items 48 to 54)

Any specialised training? ..... What degrees? .....

48. Did you use drugs during the years of schooling?

a) No (skip to item .. 54 ...)
b) Yes

49. Has there been a change in your school performance since you started using drugs? Explain.
.....
.....

50. Have you ever missed classes due to drug-taking?
.....

51. Have you ever been to class after taking drugs?
.....

52. Have you ever been detained in any class?
.....

53. Have you had any difficulties with teachers or school authorities? Explain.
.....

54. Describe your accomplishments at school — (academic performance, extra curricular activities, prizes etc)
.....
.....

If you are a student, skip items 55 — 65.

55. Are you currently employed or unemployed? .....

56. If currently unemployed, give reasons .....
.....

57. List your current or most recent occupation — describe business, name of your employer/ company, how long you have been working there.
.....
.....

58. List all jobs held, length of time, starting with the most recent. Include periods of unemployement.
.....
.....

59. Do you plan to return to your job/business when you leave here? Explain.
.....
.....

60. Are you in danger of losing your job or business at this time? Explain.
.....
.....

61. Have your co-workers or employer ever said anything to you about your drug use?
.....
.....

62. How often have you missed work or been late because of drug use. Explain.
.....
.....

63. Has drug use ever caused you to be less efficient in your work?
.....
.....

64. Have you ever received any of the following. Give reasons.
a. Verbal warnings
b. Memos
c. Suspension order
d. Increment not granted
e. Transfer
f. Resigned on request or as a protest
g. None of the above

65. Explain any other way in which your drug use has affected your work.
.....
.....

Family history

66. Has there been anyone in your family who has had any of the following:

	Relationship	Duration	Treatment	Recovered/Partial recovery/ No recovery
a. Epilepsy				
b. Mental Retardation				
c. Attempted Suicide				
d. Suicide				
e. Depression				
f. Others.....				

67. Did either of your parents use alcohol/drugs heavily?
a. No
b. Yes, who?.....

68. For how long?..... years

    How often .....

69. Were there any problems in your family associated with their use of alcohol/drugs?
    a. No
    b. Yes. What kind .....

70. Were there any deaths in your family apparently due to heavy use of alcohol/drugs?
    a. No
    b. Yes. Indicate relationship .....

71. Did anyone in your family (besides parents) use alcohol/drugs heavily?
    a. No
    b. Yes. Indicate relationship .....

72. What is (or was) your parent's attitude regarding alcohol/other drugs?
    .....
    .....

73. In your own words, describe your father's characteristics.
    .....
    .....

74. In your own words, describe your mother's characteristics.
    .....
    .....

75. How has your drug use affected your relationship with your parents? Explain.
    .....
    .....

76. Are your parents involved in your treatment for addiction? How?
    .....
    .....

If unmarried skip items 77 — 80.

77. Details regarding spouse:
    a. Name
    b. Age/Date of birth
    c. Religion/Community
    d. Education
    e. Occupation

78. In your own words, describe your spouse:
    .....
    .....

79. Details regarding children:

Age	Sex	Education	Occupation	Marital Status

80. Relationship with spouse
    a. Complete alienation, divorce, desertion details .....
    b. Usually poor relationship, blaming, hostility.
    c. Mixed, uncertain vacillating relationship
    d. Usually friendly, minor conflicts
    e. Friendly, warm, affectionate, mutual acceptance, good integration
    f. Not applicable

81. Relationship with children, parents, siblings

	Children	Parents	Siblings
a. Family has disowned you or vice versa, mutual rejection			
b. By and large alienated from family			
c. Mixed and indifferent feelings			
d. Usually friendly, minor conflicts			
e. Completely friendly, generally accepted by all or most			
f. Not applicable (dead or living distant)			

Sexual history

82. Record current sexual practices (Frequency, status of partner)
    .....
    .....

83. After you have started using drugs, what was the first noticed sexual problem?
    a. Premature ejaculation
    b. Delayed ejaculation
    c. Impotency
    d. Anorgasmia
    e. Extramarital relationship
    f. Complete abstinence
    g. Promiscuity
    h. Others
    i. None

84. Record any previous significant sexual experiences
    .....
    .....

Social life and leisure activities

85. What are your interests/hobbies?

.....

86. Do you pursue your interests and hobbies?

Regularly ..... Irregularly .....

87. Has drug use become so important or time-consuming to the extent that other interests are to some extent neglected? Explain.

.....

.....

88. What do you normally do with leisure time?

.....

89. Do you socialise with people who use drugs as you do?

.....

90. How has your social life changed as a result of drug use?

.....

91. Have any of your friends commented on your drug use? Explain.

.....

92. Have you ever lost friends because of your using drugs?

.....

.....

Legal status

93. Have you been arrested anytime? Dates and explanation of each.

.....

.....

94. Have you ever been charged? Give details.

.....

.....

95. Do you have any legal problems pending? Explain.

.....

.....

Summary of assessment

Name of patient:

History of

Loss of Memory .....
Withdrawal .....
Daily use .....
Binge use .....
Increased Tolerance .....
Decreased Tolerance .....
Preoccupation .....
Medicinal use .....
Protecting supply .....
Taking drugs to get relief from negative emotions .....
Behaviour change .....
Injury/Accidents .....
Unsuccessful attempt to limit use .....

Others .....
.....

Areas affected

Health ..... Financial ..... Vocational ..... Family ..... Sexual .....
Social ..... Legal .....

Others: (psychiatric problems, previous treatment)

.....
.....

Impression

.....
.....

Signature of Counsellor

Date:

Appendix III

THERAPY CHECKLIST

Name:

Date of Registration:

a. Current Physical problems:
   1. Liver Disease
   2. Hypertension
   3. Diabetes
   4. Any other

b. Medication:
   1. Disulfiram
   2. Antidepressants
   3. Antipsychotics
   4. Other

c. Family Participation
   1. Whom? If none, reasons

d. Support persons:
   1. Present
   2. Absent

e. Initial Motivation for Therapy: 1. Poor 2. Indifferent 3. Good

f. Identified personality problems:
   1. Low frustration tolerance
   2. Dependence
   3. Lack of confidence
   4. Irresponsibility
   5. Loneliness, Isolation
   6. Gradiosity
   7. Wishful thinking
   8. Lack of assertion
   9. Arrogance/defiance
   10. Selfishness
   11. Impulsiveness
   12. Perfectionism

g. Noticed pecularities if any:
   1. Restlessness
   2. Withdrawn
   3. Lack of concentration
   4. Intoxicated during sessions
   5. Coming late for therapy sessions
   6. Missing therapy sessions
   7. Lying
   8. Highly critical of others
   9. Argumentative
   10. Drinking/drug-taking outside sessions
   11. Planning for future drinking/drug-taking

	Week I	Week II	Week III
Normal food habits restored/maintained			
Normal sleep pattern restored/maintained			
General level of involvement in the Recovery Programme Poor/Neutral/Good/Very Good			
Group therapy participation Poor/Neutral/Good/Very Good			
Denial Mild/Moderate/Severe Is able to identify addiction Acceptance of addiction Understands importance of total abstinence			
Denial handled: Not applicable/Yes/No			
Guilt feelings dealt with Not Applicable/Yes/No			
Probed into resentments/grievances Not applicable/Yes/No			
Sexual problems, if any and whether handled Not applicable/Yes/No			
Suggested ways to overcome sudden craving Yes/No			
Discussed future drug-taking situation and relapse			
Introduction to AA/AA member NA/AA member			
Reoriented to job			
Reconciliation with spouse/family			
Life history completed			
Assignment completed			
Any other specific problems encountered			
Recovery programme completed. If not, give reasons			
Motivation at the time of discharge Poor/Indifferent/Good/Very Good			

After-care plans
(Follow-up pattern after-care group, AA/NA, medications, specific problems relating to job, family etc).

1.

2.

3.

4.

Signagure of Counsellor:

Date:

Appendix IV

GROUP THERAPY RECORD

Name Date of Registration:

Attendance

Week I Week II Week III

Behaviour observations: (Eye contact, posture, sly smiles, expressions, mannerisms etc).

Interaction in Group	Week I	Week II	Week III
High/low participation Shifts from high to low Talks more to whom Keeps the ball rolling			
Silence Positive/negative influence on group Leader/rival/neutral			
Suggests Summarises Gives or asks for facts Keeps group on target			
Helps others Begins/cuts off Preoccupied Congenial Always disagrees Indifferent			
Member of sub-groups			

Extent/Content of Sharing

Week I

Week II

Week III

Impressions

Week I

Week II

Week III

Week I Week II Week III

Signatures:

Date:

Appendix V

ASSIGNMENTS

— Here is an assignment that will help you to
  — think
  — understand
  — identify and
  — assess

  the extent of your addiction.

— Think deeply and write down whether the following things/events happened in your life. If so, when, where, and how, and what your behaviour was during these situations.

— It will help you to recover better if you are open and sincere about what you write.

Part I — Symptoms

1. Preoccupation with drugs

e.g. 1. Always thinking about when you can take the drug next (waiting for closing time of office/shop so that you can start using drugs).
2. Planning, getting and using (making schemes or plans to get money so that you can buy drugs).
3. Unable to concentrate on work because your drug-taking is delayed — postponing urgent or important work in order to take drugs.

2. Loss of memory

e.g. 1. Forgetting how you reached home the previous night
2. Totally unable to recollect promises you made while on drugs
3. Losing money and not able to remember how and when you spent it
4. Acts of aggression or anger which you were unable to recall the next day.

3. Increased tolerance

e.g. 1. Needing more and more of the drug in order to experience the same effect
2. Hiding the supply
3. Ensuring supply by stocking up
4. Trying out a combination of drugs to achive the same effect.

4. Taking drugs to relieve negative emotions

(Taking drugs to forget unpleasant events or feelings)

e.g. 1. Tension due to loss of job/death of family member

2. Anger due to a quarrel within the family

3. Criticism from the wife/boss who keeps on finding fault with whatever you do

5. Dishonesty (Lying)

e.g. 1. Coming home late and saying that there was work in the office/school

2. Saying that the salary was cut by mistake/salary was lost or stolen/given as a loan to a friens etc.

3. Saying you have a special programme/work in order to get away from home and take drugs

4. Obtaining money by saying that you have extra expenses at school/workspot — buying drugs with money given to pay fees.

6. Grandiose behaviour

e.g. 1. Pretending to be an important person, whereas deep down you feel very insignificant and unsure

2. Giving large amounts as tips/travelling in taxis (when you cannot afford it)

3. Buying expensive clothes, shoes, making unnecessary purchases for home

7. Loss of control

e.g. 1. Amount — starting with the intention of having a small quantity of drugs but ending up stoned/intoxicated

2. Time, place and company — any time becomes drug-taking time; drug-taking is associated with persons far below your social status, taking drugs with strangers; in inferior environments; being intoxicated in places where one is expected to remain sober (at religious functions; when there are guests at home)

8. Loss of other interests

e.g. 1. In family welfare (neglect of responsibilities)

2. In recreational activities (reading, films, sports, hobbies etc)

3. In personal appearance (cleanliness, clothing)

4. In all social functions except in those which involve addict friends

9. Accidents

e.g. 1. Staggering or falling on the ground, perhaps injuring oneself

2. While driving a vehicle/or getting hit by a vehicle

3. While at work

10. Aggressive behaviour

e.g. 1. Violence — beating wife/children/parents/siblings
2. Damaging/breaking household articles
3. Abusive behaviour — using foul language

11. Insane behaviour

e.g. 1. Talking/laughing/crying to oneself
2. Wandering about naked
3. Trying to commit suicide while on drugs

12. Secret guilt feelings

e.g. 1. Inability to face significant persons when sober
2. Inability to tolerate any discussion about drugs
3. Realising that drug-taking has become abnormal but not accepting it
4. Feeling bad about the consequences of previous drug-related episodes

13. Attempts to control, but fails

e.g. 1. Making vows/promising yourself and others
2. Controlling the amount/frequency of drug intake
3. Changing the drug/changing the environment, moving to a new place

Part II — Damages

1. Physical problems experienced

e.g. 1. Physical deterioration
2. Changes in appearance
3. Loss of weight
4. Inability to sleep, sleep difficulties
5. Digestive problems
6. Specific illnesses
7. Injury
8. Loss of energy, fatigue

2. Vocational

e.g. 1. Reporting for work only to save the job and doing the minimum work mechanically without interest
2. Being absent frequently
3. Employer's loss of trust (resulting in warnings, memos, suspension, finally dismissal)

4. Using capital for drugs without realising how much is being spent
5. Inability to work (both physically and mentally)
6. Attending work under the influence of drugs
7. Not accepting responsibilities, delegating all responsibilities to juniors/subordinates
8. Postponing work, missing deadlines

3. At School

e.g. 1. Attending class only to fulfilling attendance record and not taking any interest in studies.
2. Skipping classes
3. Caught taking drugs on campus — warnings, suspensions, dismissal
4. Unable to concentrate
5. Not completing assignments — postponing study
6. Skipping tests
7. Failing in tests/exams
8. Drop in grades/ranks
9. Avoiding extra-curricular activities

4. Financial

e.g. 1. Amount of money spent on drugs
2. Mounting debts
3. Loss of savings
4. Loss of pay/income due to absence from work
5. Taking advances from salary
6. Selling jewellery, property, articles, clothes, books
7. Peddling drugs to earn an income
8. Buying drugs with money given for fees and special classes

5. Social

e.g. 1. Loss of interest in social get togethers, family functions. Avoiding the same.
2. Loss of good friends and associating only with those who use drugs
3. Becoming a loner
4. Loss of reputation/respect in the community
5. Loss of trust in/from friends
6. Loss of interest in hobbies

6. Family

e.g. 1. Frequent quarrels, conflicts at home
2. Loss of communication, isolation from family members
3. Rejection by wife/parents/children/siblings
4. Not providing adequately for the family
5. Not taking family responsibilities
6. Breaching rules at home
7. Loss of love/respect/trust

7. Emotional

e.g. 1. Guilt (about money wasted, people antagonised, wife and children neglected)
2. Shame (inability to face neighbours, close relatives and significant people in one's life)
3. Self-hate (feeling worthless, loss of self-respect)
4. Fear (uncertainty about future)

8. Legal

e.g. 1. Getting arrested/fined for drunk driving
2. Arrested for being unruly while intoxicated
3. Arrested for possession of drugs
4. Arrested for peddling drugs
5. Pending legal problems

9. Values

e.g. 1. Stealing articles from home and selling them
2. Selling objects that have a sentimental value to self or to family members
3. Making wild promises in order to manipulate others
4. Peddling drugs in order to generate funds
5. Not keeping time, making people wait, arriving late for fucntions

Part III — Recovery

1. Denial

Which of the following methods did you use while taking drugs?

1. Justifying — (I took drugs because of stress at work)
2. Minimising — (I took drugs but I always did everything they wanted at home)
3. Blaming — (I took drugs because my wife keeps nagging, my parents are always controlling me)

4. Threatening — (I will go to another woman if you object to my taking drugs; I will leave the house if you object)
5. Silence — (I am not harming anybody. I never open my mouth)
6. Diverting — (Why are the children not getting good marks/why is the house untidy/why is my brother always treated better)
7. Bribing — (You can go for a film tonight. Here is the money/I will do the repair you wanted me to do)

2. Drug-taking situations

Imagine four situations when you may be tempted to take drugs. How do yo propose to handle them?

e.g. 1) New Year or a festival when people drink or get intoxicated
2) When you have really not taken drugs, your wife or parents suspect you have taken drugs
3) Suddenly you get extra money (profit/bonus)
4) When you are frustrated/depressed/angry resentful/excited

3. Values

Think and write down which of the values you have violated, and resorted to the following:

e.g. 1) Dishonesty — (lying, cheating, stealing etc)
2) Selfishness — (wanting everything for yourself — money, food, comforts)
3) Irresponsibility — (Not going to work regularly — not providing the basic necessities to wife and children disregarding rules at home)
4) Intolerance/ Impatience — Inability to accept situations which are not to your liking
e) Pride/arrogance — Inability to admit mistakes — refusal to accept advice or suggestions from others — insulting others
f) Resentment/hate — Hanging on to the displeasure aroused by real or imagined wrongs and injustice done to you.

4. Negative emotions

Examine your exaggerated negative emotions. Give examples from your life.

e.g. 1. Anger/resentment — (Sulking, refusing to accept help, shouting, beating)
2. Self-pity — (Complaining/feeling sorry for one self)
3. Anxiety/Fear — (What is going to happen to my life)
4. Inadequacy/ Inferiority — (Everybody is doing better than I am doing)
5. Envy — (All my relatives/friends are well off)

5. Goals

Short-term goals:

1. Managing finance — debts and savings
2. Immediate necessities you would like to spend on — buying clothes and other necessities
3. Changes in relation to your work routine/attendance at school
4. Social commitment/contacts
5. Taking care of your health
6. Treatment related plans, after-care
7. Completing exams — clearing papers
8. Gaining employment

Life History

Write in detail, openly and honestly what you remember of your life so far.

1. Start from your childhood, stating any significant event from your childhood to your adolescence.
2. Say when and how you started using alcohol or drugs, and the pattern of use.
3. Write about the damages caused by drugs to your physical, emotional, social and family life.
4. Write how you came to this centre, the initial feelings when you entered the centre and your present feelings.
5. Write about your plan of action and the steps you will take to stay sober.

Appendix VI

FOLLOW-UP RECORD

Name of patient:
Address & Phone No.:

Date of Registration
Status on discharge:
(Completed treatment, drop-out)
Name of Counsellor:

	At 3 months	At 6 months	At 12 months
Source of follow up: Patient visited Others visited Letter received from patient/others Letter sent by Counsellor Home-visits etc	Date	Date	Date
Drug-use Quantity, frequency, pattern	Date	Date	Date
Health Status Financial Status Vocational Functioning Family Relations Social/recreational activities	Date	Date	Date
Medication	Date	Date	Date
Attends AA/NA	Date	Date	Date
Counselling	Date	Date	Date

ADDENDA :

SCORING KEY

Q. No.	Selzer Weight Yes	Selzer Weight No	Points	Unit Weight Yes	Unit Weight No	Points
1.		✓	2		✓	1
2.	✓		2	✓		1
3.	✓		1	✓		1
4.		✓	2		✓	1
5.	✓		1	✓		1
6.		✓	2		✓	1
7.	✓		0	✓		1
8.		✓	2		✓	1
9.	✓		5	✓		1
10.	✓		1	✓		1
11.	✓		2	✓		1
12.	✓		2	✓		1
13.	✓		2	✓		1
14.	✓		2	✓		1
15.	✓		2	✓		1
16.	✓		2	✓		1
17.	✓		1	✓		1
18.	✓		2	✓		1
19.	✓		2	✓		1
20.	✓		5	✓		1
21.	✓		5	✓		1
22.	✓		2	✓		1
23.	✓		2	✓		1
24.	✓		2	✓		1
25.	✓		2	✓		1

Interpretation

Master Score (Selzer Weight)	Mast Score (Unit Weight)	Level of Evidence
0	0	No Evidence
1-4	1-2	Low
5-6	3-5	Some Evidence
7-25	6-13	Clear Evidence
25-39	14-20	Substantial
40-53	21-24	Severe

ADDENDA :

SCORING KEY

Q. No.	Selzer Weight		Points	Unit Weight		Points
	Yes	No		Yes	No	
1.		✓	2		✓	1
2.	✓		2	✓		1
3.	✓		1	✓		1
4.		✓	2		✓	1
5.	✓		1	✓		1
6.		✓	2		✓	1
7.	✓		0	✓		1
8.		✓	2		✓	1
9.	✓		5	✓		1
10.	✓		1	✓		1
11.	✓		2	✓		1
12.	✓		2	✓		1
13.	✓		2	✓		1
14.	✓		2	✓		1
15.	✓		2	✓		1
16.	✓		2	✓		1
17.	✓		1	✓		1
18.	✓		2	✓		1
19.	✓		2	✓		1
20.	✓		5	✓		1
21.	✓		5	✓		1
22.	✓		2	✓		1
23.	✓		2	✓		1
24.	✓		2	✓		1
25.	✓		2	✓		1

Interpretation

Maser Score (Selzer Weight)	Masi Score (Unit Weight)	Level of Evidence
0	0	No Evidence
1-4	1-2	Low
5-6	3-5	Some Evidence
7-25	6-13	Clear Evidence
25-39	14-20	Substantial
40-53	21-24	Severe