A.A. Tradition
How It Developed

By BILL W.

A Tour of the
Historical Events
That Led to Our Unique
Twelve Traditions

ALCOHOLICS ANONYMOUS *is a fellowship of men and women who share their experience, strength and hope with each other 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 A.A. membership; we are self-supporting through our own contributions.*
- *A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes.*
- *Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.*

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THIS pamphlet tells the story of the emergence and development of the principles believed essential to A.A. unity and survival.

Bill W.'s foreword presents in their original form the "Twelve Points to Assure Our Future." In all but the Second Tradition, the original language has been modified or shortened.

There are two pieces by Bill W. on the Anonymity Traditions, one written when the Fellowship was eleven years old; the other nine years later. Together they buttress our best known—and perhaps least understood—Traditions, Eleven and Twelve.

Foreword

by Bill W.

—1955*—

How shall we A.A.'s best preserve our unity? That is the subject of this booklet.

When an alcoholic applies the Twelve Steps of our recovery program to his personal life, his *disintegration* stops and his *unification* begins. The Power which now holds him together in one piece overcomes those forces which had rent him apart.

Exactly the same principle applies to each A.A. group and to Alcoholics Anonymous as a whole. So long as the ties which bind us together prove far stronger than those forces which would divide us if they could, all will be well. We shall be secure as a movement; our essential unity will remain a certainty.

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* Originally published in The A.A. Grapevine.

If, as A.A. members, we can each refuse public prestige and renounce any desire for personal power; if, as a movement, we insist on remaining poor, so avoiding disputes about extensive property and its management; if we steadfastly decline all political, sectarian, or other alliances, we shall avoid internal division and public notoriety; if, as a movement, we remain a spiritual entity concerned only with carrying our message to fellow sufferers without charge or obligation; then only can we most effectively complete our mission. It is becoming ever so clear that we ought never accept even the most alluring temporary benefits if these should consist of considerable sums of money, or could involve us in controversial alliances and endorsements, or might tempt some of us to accept, as A.A. members, personal publicity by press or radio. Unity is so vital to us A.A.'s that we cannot risk those attitudes and practices which have sometimes demoralized other forms of human society. Thus far we have succeeded because we have been different. May we continue to be so!

But A.A. unity cannot automatically preserve itself. Like personal recovery, we shall always have to work to maintain it. Here, too, we surely need honesty, humility, open-mindedness, unselfishness, and, above all—vigilance. So we who are older in A.A. beg you who are newer to ponder carefully the experience we have already had of trying to work and live together. We would like each A.A. to become just as much aware of those disturbing tendencies which endanger us as a whole as he is conscious of those personal defects which threaten his own sobriety and peace of mind. For whole movements have, before now, gone on benders, too!

The "Twelve Points of A.A. Tradition" reproduced herein is our first attempt to state sound principles of group conduct and public relations. As one of the originators of A.A., I was asked to publish these "Points," together with supporting articles, serially in our principal monthly journal, The A.A. Grapevine. Many A.A.'s already feel that these Twelve Traditions are sound enough to become the basic guide and protection for A.A. as a whole; that we ought to apply them as seriously to our group life as we do the Twelve Recovery Steps to ourselves individually. Of this, it will take time to tell.

May we never forget that without permanent unity we can offer little lasting relief to those scores of thousands yet to join us in their quest for freedom.

Nobody invented Alcoholics Anonymous. It grew. Trial-and-error has produced a rich experience. Little by little we have been adopting the lessons of that experience, first as policy and then as tradition. That process still goes on and we hope it never stops. Should we ever harden too much, the letter might crush that spirit. We could victimize ourselves by petty rules and prohibitions; we could imagine that we had said the last word. We might even be asking alcoholics to accept our rigid ideas or stay away. May we never stifle progress like that!

Yet the lessons of our experience count for a great deal. We now have had years of vast acquaintance with the problem of living and working together. If we can succeed in this adventure—and keep succeeding—then, and only then, will our future be secure.

Since personal calamity holds us in bondage no more, our most challenging concern has become the future of Alcoholics Anonymous; how to preserve among us A.A.'s such a powerful unity that neither weakness of persons nor the strain and strife of these troubled times can harm our common cause. We know that Alcoholics Anonymous must continue to live. Else, save few exceptions, we and our brother alcoholics throughout the world will surely resume the hopeless journey to oblivion.

Almost any A.A. can tell you what our group problems are. Fundamentally they have to do with our relations, one with the other, and with the world outside. They involve relations of the A.A. to his group, the relation of his group to Alcoholics Anonymous as a whole, and the place of Alcoholics Anonymous in that troubled sea called modern society, where all of humankind must presently shipwreck or find haven. Terribly relevant is the problem of our basic structure and our attitude toward those ever-pressing questions of leadership, money, and authority. The future may well depend on how we feel and act about things that are controversial and how we regard our public relations. Our final destiny will almost surely hang upon what we presently decide to do with these danger-fraught issues!

Now comes the crux of our discussion. It is this: Have we yet acquired sufficient experience to state clear-cut policies on these, our chief concerns; can we now declare general principles which could grow into vital traditions—traditions sustained in the heart of each A.A. by his own deep conviction and by the common consent of his fellows? That is the question. Though full answers to all our per-

plexities may never be found, I'm sure we have come at last to a vantage point whence we can discern the main outlines of a body of tradition which, God willing, can stand as an effective guard against all the ravages of time and circumstance.

Acting upon the persistent urge of old A.A. friends, and upon the conviction that general agreement and consent among our members are now possible, I shall venture to place in words these suggestions for An Alcoholics Anonymous Tradition of Relations—Twelve Points to Assure Our Future:

Our A.A. experience has taught us that:

1.—Each member of Alcoholics Anonymous is but a small part of a great whole. A.A. must continue to live or most of us will surely die. Hence our common welfare comes first. But individual welfare follows close afterward.

(Our common welfare should come first; personal recovery depends upon A.A. unity.)

2.—For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience.

(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.—Our membership ought to include all who suffer alcoholism. Hence we may refuse none who wish to recover. Nor ought A.A. membership ever depend upon money or conformity. Any two or three alcoholics gathered together for sobriety may call themselves an A.A. group, provided that, as a group, they have no other affiliation.

(The only requirement for A.A. membership is a desire to stop drinking.)

4.—With respect to its own affairs, each A.A. group should be responsible to no other authority than its own conscience. But when its plans concern the welfare of neighboring groups also, those groups ought to be consulted. And no group, regional committee, or individual should ever take any action that might greatly affect A.A. as a whole without conferring with the trustees of The Alcoholic Foundation.* On such issues our common welfare is paramount.

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* Now known as The General Service Board of A.A., Inc.

(Each group should be autonomous except in matters affecting other groups or A.A. as a whole.)

5.—Each Alcoholics Anonymous group ought to be a spiritual entity *having but one primary purpose*—that of carrying its message to the alcoholic who still suffers.

(Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.)

6.—Problems of money, property, and authority may easily divert us from our primary spiritual aim. We think, therefore, that any considerable property of genuine use to A.A. should be separately incorporated and managed, thus dividing the material from the spiritual. An A.A. group, as such, should never go into business. Secondary aids to A.A., such as clubs or hospitals which require much property or administration, ought to be incorporated and so set apart that, if necessary, they can be freely discarded by the groups. Hence such facilities ought not use the A.A. name. Their management should be the sole responsibility of those people who financially support them. For clubs, A.A. managers are usually preferred. But hospitals, as well as other places of recuperation, ought to be well outside A.A.—and medically supervised. While an A.A. group may cooperate with anyone, such cooperation ought never go so far as affiliation or endorsement, actual or implied. An A.A. group can bind itself to no one.

(An A.A. group ought never endorse, finance or lend the A.A. name to any related facility or outside enterprise lest problems of money, property and prestige divert us from our primary purpose.)

7.—The A.A. groups themselves ought to be fully supported by the voluntary contributions of their own members. We think that each group should soon achieve this ideal; that any public solicitation of funds using the name of Alcoholics Anonymous is highly dangerous, whether by groups, clubs, hospitals, or other outside agencies; that acceptance of large gifts from any source, or of contributions carrying any obligations whatever, is unwise. Then too, we view with much concern those A.A. treasuries which continue, beyond prudent reserves, to accumulate funds for no stated A.A. purpose. Experience has often warned us that nothing can so surely destroy our spiritual heritage as futile disputes over property, money, and authority.

(Every A.A. group ought to be fully self-supporting, declining outside contributions.)

8.—Alcoholics Anonymous should remain forever nonprofessional. We define professionalism as the occupation of counseling alcoholics for fees or hire. But we may employ alcoholics where they are going to perform those services for which we might otherwise have to engage nonalcoholics. Such special services may be well recompensed. But our usual A.A. Twelfth Step work is never to be paid for.

(Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.)

9.—Each A.A. group needs the least possible organization. Rotating leadership is the best. The small group may elect its secretary, the large group its rotating committee, and the groups of a large metropolitan area their central or intergroup committee, which often employs a full-time secretary. The trustees of The Alcoholic Foundation are, in effect, our A.A. General Service Committee. They are the custodians of our A.A. tradition and the receivers of voluntary A.A. contributions by which we maintain our A.A. General Service Office at New York. They are authorized by the groups to handle our overall public relations and they guarantee the integrity of our principal journal, The A.A. Grapevine. All such representatives are to be guided in the spirit of service, for true leaders in A.A. are but trusted and experienced servants of the whole. They derive no real authority from their titles; they do not govern. Universal respect is the key to their usefulness.

(A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.)

10.—No A.A. group or member should ever, in such a way as to implicate A.A., express any opinion on outside controversial issues—particularly those of politics, alcohol reform, or sectarian religion. The Alcoholics Anonymous groups oppose no one. Concerning such matters they can express no views whatever.

(Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.)

11.—Our relations with the general public should be characterized by personal anonymity. We think A.A. ought to avoid sensational advertising. Our names and pictures as A.A. members ought not be broadcast, filmed, or publicly printed. Our public relations should be guided by the principle of attraction rather than promotion. There is never need to praise ourselves. We feel it better to let our friends recommend us.

(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.—And finally, we of Alcoholics Anonymous believe that the principle of anonymity has an immense spiritual significance. It reminds us that we are to place principles before personalities; that we are actually to practice a genuine humility. This to the end that our great blessings may never spoil us; that we shall forever live in thankful contemplation of Him Who presides over us all.

(Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.)

WHO IS A MEMBER OF ALCOHOLICS ANONYMOUS?

—1946—

(Tradition Three grew out of this piece by Bill W. in The A.A. Grapevine)

The first edition of the book "Alcoholics Anonymous" makes this brief statement about membership: "The only requirement for membership is an honest desire to stop drinking. We are not allied with any particular faith, sect, or denomination nor do we oppose anyone. We simply wish to be helpful to those who are afflicted." This expressed our feelings as of 1939, the year our book was published.

Since that day all kinds of experiments with membership have been tried. The number of membership rules which have been made (and mostly broken!) are legion. Two or three years ago the General Office asked the groups to list their membership rules and send them in. After they arrived we set them all down. They took a great many sheets of paper. A little reflection upon these many rules brought us to an astonishing conclusion. If all of these edicts had been in force everywhere at once it would have been practically impossible for any alcoholic to have ever joined Alcoholics Anonymous. About nine-tenths of our oldest and best members could never have got by!

In some cases we would have been too discouraged by the demands made upon us. Most of the early members of A.A. would have been thrown out because they slipped too much, because their morals were too bad, because they had mental as well as alcoholic difficulties. Or, believe it or not, because they did not come from the so-called better classes of society. We oldsters could have been excluded for our failure to read the book "Alcoholics Anonymous" or the refusal of our sponsor to vouch for us as a candidate. And so on ad infinitum. The way our "worthy" alcoholics have sometimes tried to judge the "less worthy" is, as we look back on it, rather comical. Imagine, if you can, one alcoholic judging another!

At one time or another most A.A. groups go on rule-making benders. Naturally enough, too, as a group commences to grow rapidly it is confronted with many alarming problems. Panhandlers begin to panhandle. Members get drunk and sometimes get others drunk with them. Those with

mental difficulties throw depressions or break out into paranoid denunciations of fellow members. Gossips gossip and righteously denounce the local Wolves and Red Riding Hoods. Newcomers argue that they aren't alcoholics at all, but keep coming around anyway. "Slippees" trade on the fair name of A.A. in order to get themselves jobs. Others refuse to accept all the Twelve Steps of the recovery program. Some go still further, saying that the "God business" is bunk and quite unnecessary. Under these conditions our conservative program-abiding members get scared. These appalling conditions must be controlled, they think, else A.A. will surely go to rack and ruin. They view with alarm for the good of the movement!

At this point the group enters the rule and regulation phase. Charters, bylaws and membership rules are excitedly passed and authority is granted committees to filter out undesirables and discipline the evildoers. Then the Group Elders, now clothed with authority, commence to get busy. Recalcitrants are cast into the outer darkness; respectable busybodies throw stones at the sinners. As for the so-called sinners, they either insist on staying around, or else they form a new group of their own. Or maybe they join a more congenial and less intolerant crowd in their neighborhood. The elders soon discover that the rules and regulations aren't working very well. Most attempts at enforcement generate such waves of dissension and intolerance in the group that this condition is presently recognized to be worse for the group life than the very worst that the worst ever did.

After a time fear and intolerance subside. The group survives unscathed. Everybody has learned a great deal. So it is that few of us are any longer afraid of what any newcomer can do to our A.A. reputation or effectiveness. Those who slip, those who panhandle, those who scandalize, those with mental twists, those who rebel at the program, those who trade on the A.A. reputation—all such persons seldom harm an A.A. group for long. Some of these have become our most respected and best loved. Some have remained to try our patience, sober nevertheless. Others have drifted away. We have begun to regard these not as menaces, but rather as our teachers. They oblige us to cultivate patience, tolerance, and humility. We finally see that they are only people sicker than the rest of us, that we who condemn them are the Pharisees whose false righteousness does our group the deeper spiritual damage.

Every older A.A. shudders when he remembers

the names of persons he once condemned; people he confidently predicted would never sober up; persons he was sure ought to be thrown out of A.A. for the good of the movement. Now that some of these very persons have been sober for years, and may be numbered among his best friends, the old-timer thinks to himself, "What if everybody had judged these people as I once did? What if A.A. had slammed its door in their faces? Where would they be now?"

That is why we all judge the newcomer less and less. If alcohol is an uncontrollable problem *to him* and *he* wishes to do something about it, that is enough for us. We care not whether his case is severe or light, whether his morals are good or bad, whether he has other complications or not. Our A.A. door stands wide open, and if he passes through it and commences to do anything at all about his problem, he is considered a member of Alcoholics Anonymous. He signs nothing, agrees to nothing, promises nothing. We demand nothing. He joins us on his own say-so. Nowadays, in most groups, he doesn't even have to admit he is an alcoholic. He can join A.A. on the mere suspicion that he may be one, that he may already show the fatal symptoms of our malady.

Of course this is not the universal state of affairs throughout A.A. Membership rules still exist. If a member persists in coming to meetings drunk he may be led outside; we may ask someone to take him away. But in most groups he can come back next day, if sober. Though he may be thrown out of a club, nobody thinks of throwing him out of A.A. He is a member as long as he says he is. While this broad concept of A.A. membership is not yet unanimous, it does represent the main current of A.A. thought today. We do not wish to deny anyone his chance to recover from alcoholism. We wish to be just as inclusive as we can, never exclusive.

Perhaps this trend signifies something much deeper than a mere change of attitude on the question of membership. Perhaps it means that we are losing all fear of those violent emotional storms which sometimes cross our alcoholic world; perhaps it bespeaks our confidence that every storm will be followed by a calm; a calm which is more understanding, more compassionate, more tolerant than any we ever knew before.

HOSPITALS AND A.A.

(Excerpts from Bill W.'s "Adequate Hospitalization" article in The A.A. Grapevine in 1947 . . . background for Tradition Six)

Many sanitariums and private hospitals are necessarily too high priced for the average alcoholic. Public hospitals being too few, asylums and religious institutions too seldom available, the average group has been hard put to find spots where prospective members can be hospitalized a few days at modest expense.

This urgency has tempted some A.A. groups to set up drying-out places of their own, hiring A.A. managers, nurses, and securing the services of a visiting physician. Where this has been done under the direct auspices of an A.A. group it has almost always backfired. It has put the group into business, a kind of business about which few A.A.'s know anything at all. Too many clashing personalities, too many cooks spoiling the broth, usually bring about the abandonment of such attempts. We have been obliged to see that an A.A. group is primarily a spiritual entity; that, as a group the less business it has to transact, the better. While on this theme it ought to be noted that practically all group schemes to finance or guarantee hospital bills for fellow members have failed also. Not only do many such loans go unpaid, there is always the controversial question in the group as to which prospects deserve them in the first place.

In still other instances A.A. groups, driven by their acute need for medical aid, have started public money-raising campaigns to set up "A.A. hospitals" in their communities. These efforts almost invariably come to naught. Not only do these groups intend to go into the hospital business, they intend to finance their ventures by soliciting the public in the name of Alcoholics Anonymous. Instantly all sorts of doubts are generated; the projects bog down. Conservative A.A.'s realize that business ventures or solicitations carrying the A.A. endorsement are truly dangerous to us all. Were this practice to become general the lid would be off. Promoters, A.A. and otherwise, would have a field day.

This search for reasonably priced and understanding medical treatment has brought into being still another class of facilities. These are rest farms

and drying-out places operated by individual A.A.'s under suitable medical supervision. These setups have proved far more satisfactory than group-directed projects. As might be expected their success is in exact proportion to the managerial ability and good faith of the A.A. in charge. If he is able and conscientious, a very good result is possible; if neither, the place folds up. Not being a group project and not bearing the A.A. name, these ventures can be taken or left alone. The operation of such establishments is always beset with peculiar difficulties. It is difficult for the A.A. manager to charge high enough rates to make the venture include a fair living for himself. If he does, people are apt to say that he is professionalizing, or "making money out of A.A." Nonsense though this may often be, it is a severe handicap nevertheless.

Yet, in spite of the headaches encountered, a good number of these farms and sobering-up spots are in active operation and can seemingly continue just as long as they are tactfully managed, do not carry the A.A. name, and do not publicly solicit funds as A.A. enterprises. When a place has an A.A. in charge we sometimes do take thoughtless advantage of the fact. We dump alcoholics into it just to get them off our hands; we promise to pay bills and do not. Any A.A. who can successfully manage one of these "drunk emporiums" ought to be congratulated. It is a hard and often thankless job though it may bring him deep spiritual satisfaction. Perhaps this is the reason so many A.A.'s wish to try it!

CLUBS IN A.A. ARE THEY WITH US TO STAY?

—1947*—

(More background for Tradition Six)

The club idea has become part of A.A. life. Scores of these hospitable havens can report years of useful service; new ones are being started monthly. Were a vote taken tomorrow on the desirability of clubs a sizable majority of A.A.'s would record a resounding "yes." There would be thousands who would testify that they might have had a harder time staying sober in their first months of A.A. without clubs and that in any case, they would always wish for the easy contacts and warm friendships which clubs afford.

Being the majority view, we might suppose that a blanket endorsement for clubs; we might think we couldn't get along without them. We might conceive them as a central A.A. institution—a sort of "Thirteenth Step" of our recovery program without which the other Twelve Steps wouldn't work. At times club enthusiasts will act as though they really believed we could handle our alcoholic problems by club life alone. They are apt to depend upon clubs rather than upon the A.A. program.

But we have A.A.'s, rather a strong minority, too, who want no part of clubs. Not only, they assert, does the social life of a club often divert the attentions of members from the program, they claim that clubs are an actual drag on A.A. progress. They point to the danger of clubs degenerating into mere hangouts, even "joints"; they stress the bickerings that do arise over questions of money, management, and personal authority; they are afraid of "incidents" that might give us unfavorable publicity. In short, they "view with alarm." Thumbs down on clubs, they say.

Toward a middle ground, for several years now, we have been feeling our way. Despite alarms it is quite settled that A.A.'s who need and want clubs ought to have them. So the real concern is not whether we shall have clubs. It is how we shall enhance them as assets, how we may diminish their known liabilities; how we shall be sure, in the long future, that their liabilities do not exceed their assets.

Originally published in The A.A. Grapevine.

Of our four largest A.A. centers, two are club-minded and two are not. I happen to live in one which is. The very first A.A. club was started in New York. Though our experience here may not have been the best, it is the one I know. So, by way of portraying the principles and problems we need to discuss, I shall use it, as an average illustration of club evolution, rather than as a model setup.

When A.A. was very young we met in homes. People came miles, not only for the A.A. meeting itself, but to sit hours afterward at coffee, cake, and eager, intimate talk Alcoholics and their families had been lonely too long.

Then homes became too small. We couldn't bear to break up into many little meetings, so we looked for a larger place. We lodged first in the workshop of a tailoring establishment, then in a rented room at Steinway Hall. This kept us together during the meeting hour. Afterward we held forth at a cafeteria, but something was missing. It was the home atmosphere; a restaurant didn't have enough of it. Let's have a club, someone said.

So we had a club. We took over an interesting place, the former Artists and Illustrators Club on West 24th Street. What excitement! A couple of older members signed the lease. We painted and we scrubbed. We had a home. Wonderful memories of days and nights at that first club will always linger.

But, it must be admitted, not all those memories are ecstatic. Growth brought headaches; growing pains, we call them now. How serious they seemed then! "Dictators" ran amuck; drunks fell on the floor or disturbed the meetings; "steering committees" tried to nominate their friends to succeed them and found to their dismay that even sober drunks couldn't be "steered." Sometimes we could scarcely get up the rent; card players were impervious to any suggestion that they talk to new people (nowadays, most clubs have abandoned card playing altogether); lady secretaries got in each other's hair. A corporation was formed to take over the clubroom lease so we then had "officials." Should these "directors" run the club or would it be the A.A. rotating committee?

Such were our problems. We found the use of money, the need for a certain amount of club organization, and the crowded intimacy of the place created situations we hadn't anticipated. Club life still had great joys. But it had liabilities too, that was for sure. Was it worth all the risk and trouble? The answer was "yes," for the 24th Street Club kept

right on going, and is today occupied by the A.A. seamen.* We have, besides, three more clubs in this area; a fourth is contemplated.

Our first club was known, of course, as an "A.A. clubhouse." The corporation holding its lease was titled "Alcoholics Anonymous of New York, Inc." Only later did we realize we had incorporated the whole of New York State, a mistake recently rectified. Of course our incorporation should have covered "24th Street" only. Throughout the country most clubs have started like ours did. At first we regarded them as central A.A. institutions. But later experience invariably brings a shift in their status. A shift much to be desired, we now think.

For example, the early Manhattan A.A. club had members from every section of the metropolitan area, including New Jersey. After a while dozens of groups sprang up in our suburban districts. They got themselves more convenient meeting places. Our Jersey friends secured a club of their own. So these outlying groups originally spawned from the Manhattan clubhouse began to acquire hundreds of members who were not tied to Manhattan either by convenience, inclination, or old-time sentiment. They had their own local A.A. friends, their own convenient gathering places. They weren't interested in Manhattan.

This irked New Yorkers not a little. Since we had nurtured them, why shouldn't they be interested? We were puzzled why they refused to consider the Manhattan club the A.A. center for the metropolitan area. Wasn't the club running a central meeting with speakers from other groups? Didn't we maintain a paid secretary who sat in the New York clubhouse taking telephone calls for assistance and making hospital arrangements for all groups in the area? Of course, we thought, our outlying groups ought financially to support the Manhattan club; dutiful children should look after their "parents." But our parental pleas were of no use. Though many outlying A.A. members personally contributed to the 24th Street Club, nary a cent did their respective groups ever send in.

Then we took another tack. If the outlying groups would not support the club, they at least might want to pay the salary of its secretary. She was really doing an "area" job. Surely this was a reasonable request. But it never got anywhere. They just couldn't mentally separate the "area

* The building was later torn down.

secretary" from the Manhattan club. So, for a long time, our area needs, our common A.A. problem, and our club management were tied into a trying financial and psychological snarl.

This tangle slowly commenced to unravel, as we began to get the idea that clubs ought to be strictly the business of those individuals who specially want clubs, and who are willing to pay for them. We begin to see that club management is a large business proposition which ought to be separately incorporated under another name—"Alanon," for example; that the "directors" of a club corporation ought to look after club business only; that an A.A. group, as such, should never get into active management of a business project. Hectic experience has since taught us that if an A.A. rotating committee tries to boss the club corporation or if the corporation tries to run the A.A. affairs of those groups who may meet at the club, there is difficulty at once. The only way we have found to cure this is *to separate the material from the spiritual.* If an A.A. group wishes to use a given club, let them pay rent or split the meeting take with the club management. To a small group opening its first clubroom, this procedure may seem silly because, for the moment, the group members will also be club members. Nevertheless separation by early incorporation is recommended because it will save much confusion later on as other groups start forming in the area.

Questions are often asked: "Who elects the business directors of a club?" "Does club membership differ from A.A. membership?" "How are clubs supported and financed?" As practices vary, we don't quite know the answers yet. The most reasonable suggestions seem these: any A.A. member ought to feel free to enjoy the ordinary privileges of an A.A. club whether he makes a regular voluntary contribution or not. If he contributes regularly, he should, in addition, be entitled to vote in the business meetings which elect the business directors of his club corporation. This would open all clubs to all A.A.'s. But it would limit their business conduct to those interested enough to contribute regularly. In this connection, we might remind ourselves that in A.A. we have no fees or compulsory dues. But it ought to be added, of course, that since clubs are becoming separate and private ventures, they can be run on other lines if their members insist.

Acceptance of large sums from *any source* to buy, build, or finance clubs almost invariably leads

to later headaches. Public solicitation is, of course, extremely dangerous. Complete self-support of clubs and everything else connected with A.A. is becoming our universal practice.

Club evolution is also telling us this: in none but small communities are clubs likely to remain the principal centers of A.A. activity. Originally starting as the main center of a city, many a club moves to larger and larger quarters thinking to retain the central meeting for its area within its own walls. Finally, however, circumstances defeat this purpose.

Circumstance number one is that the growing A.A. will burst the walls of any clubhouse. Sooner or later the principal or central meeting has to be moved into a larger auditorium. The club can't hold it. This is a fact which ought to be soberly contemplated whenever we think of buying or building large clubhouses. A second circumstance seems sure to leave most clubs in an "off center" position, especially in large cities. That is our strong tendency toward central or intergroup committee management of the common A.A. problems of metropolitan areas. Every area, sooner or later, realizes that such concerns as intergroup meetings, hospital arrangements, local public relations, a central office for interviews and information, are things in which every A.A. is interested, whether he has any use for clubs or not. These being strictly A.A. matters, a central or intergroup committee has to be elected and financed to look after them.

Groups of an area will usually support with group funds these truly central activities. Even though the club is still large enough for intergroup meetings and these meetings are still held, the center of gravity for the area will continue to shift to the intergroup committee and its central activities. The club is left definitely outside, where, in the opinion of many, it should be. Actively supported and managed by those who want clubs, they can be "taken or left alone."

If you have a CLUB problem, write also for the free service bulletin "A.A. Guidelines on CLUBS."

DANGERS IN LINKING A.A. TO OTHER PROJECTS

—1947*—

(Dangers which Traditions Six and Eight recognize)

Our A.A. experience has been raising the following set of important, but as yet unresolved, questions. First, should A.A. as a whole enter the outside fields of hospitalization, research and noncontroversial alcohol education? Second, is an A.A. member, acting strictly as an individual, justified in bringing his special experience and knowledge into such enterprises? And thirdly, if an A.A. member does take up these phases of the total alcohol problem, under what conditions should he work?

With respect to these questions, almost any opinion can be heard among our groups. Generally speaking, there are three schools of thought: the "do everything" school; the "do something" school; and the "do nothing" school.

We have A.A.'s so fearful we may become entangled, or somewhat exploited, that they would keep us a strictly closed corporation. They would exert the strongest possible pressure to prevent all A.A.'s, whether as individuals or groups, from doing anything at all about the total alcohol problem, except, of course, their straight A.A. work. They see the specter of the Washingtonian movement among alcoholics of a hundred years ago which fell into disunity partly because its members publicly took up cudgels for abolition, prohibition—and whatnot. These A.A.'s believe that we must preserve our isolation at any cost; that we must keep absolutely to ourselves if we would avoid like perils.

Then we have the A.A. who would have us "do everything" for the total alcohol problem—any time, any place and any way! In his enthusiasm, he not only thinks his beloved A.A. a "cure-all" for drunks, but he also thinks we have the answer for everybody and everything touching alcohol. He strongly feels that A.A. ought to place its name and financial credit squarely behind any first-rate research, hospital or educational project. Seeing that A.A. now makes the headlines, he argues that we should freely loan out our huge goodwill. Says he, "Why shouldn't we A.A.'s stand right up in public and be counted? Millions could be raised easily for good works in alcohol." The judgment of this enthusiast is sometimes beclouded by the fact he wants to make a career. But with most who enthuse so carelessly, I'm sure it's more often a case of sheer exuberance plus, in many instances, a deep sense of social responsibility.

So we have with us the enthusiasts and the ultra-cautious; the "do everythings" and the "do nothings." But the average A.A. is not so worried about these phenomena as he used to be. He knows that out of the heat and smoke there will soon come light. Presently there will issue an enlightened policy, palatable to everyone. Tested by time, that policy, if sound, will become A.A. tradition.

Sometimes I've feared that A.A. would never bring forth a workable policy. Nor was my fear abated as my own views swung with complete inconsistency from one extreme to the other. But I should have had more faith. We are commencing to have enough of the strong light of experience to see more surely; to be able to say with more certainty what we can and what we surely cannot do about causes such as education, research and the like.

For example, we can say quite emphatically that neither A.A. as a whole nor any A.A. group ought to enter any activity other than straight A.A. As groups, we cannot endorse, finance or form an alliance with any other cause, however good; we cannot link the A.A. name to other enterprises in the alcohol field to the extent that the public gets the impression we have abandoned our sole aim. We must discourage our members and our friends in these fields from stressing the A.A. name in their publicity or appeals for funds. To act otherwise will certainly imperil our unity, and to maintain our unity is surely our greatest obligation —to our brother alcoholics and the public at large. Experience, we think, has already made these principles self-evident.

Though we now come to more debatable ground, we must earnestly ask ourselves whether any of us, as individuals, ought to carry our special experience into other phases of the alcohol problem. Do we not owe this much to society, and can it be done without involving A.A. as a whole?

To my mind, the "do nothing" policy has become unthinkable, partly because I'm sure that

* Originally published in The A.A. Grapevine.

our members can work in other noncontroversial alcohol activities without jeopardizing A.A., if they observe a few simple precautions, and partly because I have developed a deep conviction that to do less would be to deprive the whole of society of the immensely valuable contributions we could almost certainly make. Though we are A.A.'s, and A.A. must come first, we are also citizens of the world. Besides, we are, like our good friends the physicians, honor-bound to share all we know with all men.

Therefore it seems to me that some of us must heed the call from other fields. And those who do need only remember first and last they are A.A.'s; that in their new activities they are individuals only. This means that they will respect the principle of anonymity in the press; that if they do appear before the general public they will not describe themselves as A.A.'s; that they will refrain from emphasizing their A.A. status in appeals for money or publicity.

These simple principles of conduct, if conscientiously applied, could soon dispel all fears, reasonable and unreasonable, which many A.A.'s now entertain. On such a basis A.A. as a whole could remain uncommitted yet friendly to any noncontroversial cause seeking to write a brighter page in the dark annals of alcoholism.

Briefly summarizing, I'm rather sure our policy with respect to "outside" projects will turn out to be this: A.A. does not sponsor projects in other fields. But, if these projects are constructive and noncontroversial in character, A.A. members are free to engage in them without criticism if they act as individuals only, and are careful of the A.A. name. Perhaps that's it. Shall we try it?

MONEY

—1946*—

(What led up to the writing of Tradition Seven)

In Alcoholics Anonymous, does money make the mare go or is it the root of all evil? We are in the process of solving that riddle. Nobody pretends to have the complete answer. Where the proper use of money ends—and its misuse begins—is the point in "spiritual space" we are all seeking. Few group problems are giving thoughtful A.A.'s more concern than this. Everyone is asking, "What shall be our attitude toward voluntary contributions, paid workers, professionalism, and outside donations?"

In the first years of A.A. we had no money problems. We met in homes where our womenfolk made sandwiches and coffee. If an individual A.A. wished to grubstake a fellow alcoholic, he did so. It was purely his own affair. We had no group funds, hence no group money troubles. And it must be recorded that many an old-time A.A. wishes we could now return to those early days of halcyon simplicity. Knowing that quarrels over material things have crushed the spirit of many a good undertaking, it is often thought that too much money may prove an evil for us too.

It's small use yearning for the impossible. Money *has* entered our picture and we *are definitely committed* to its sparing use. No one would seriously think of abolishing our meeting places and clubs for the sake of avoiding money altogether. Experience has shown that we very much need these facilities, so we must accept whatever risk there is in them.

But how shall we keep these risks to a minimum; how shall we traditionally limit the use of money so that it may never topple the spiritual foundation upon which each A.A. life so completely depends? That is our real problem today. So let us look together at the main phases of our financial situation, seeking to discover what is essential, what is nonessential, what is legitimate and harmless, and what may be dangerous or unnecessary.

Suppose we begin with voluntary contributions. Each A.A. finds himself dropping money in "the hat" to pay the rent of a meeting place, a club, or the maintenance of his local or national headquarters. Though not all of us believe in clubs,

* Originally published in The A.A. Grapevine.

and while a few A.A.'s see no necessity for any local or national offices, it can be said fairly that the vast majority of us believe that these services are basically necessary. Provided such facilities are efficiently handled, and their funds properly accounted for, we are only too glad to pledge them our regular support, with the full understanding, of course, that such contributions are in no wise a condition of our A.A. membership. These particular uses of our money are now generally accepted and, with some qualifications, there is little worry of dire long-range consequences.

Yet some concern does remain, arising mostly in connection with our clubs, local offices and the General Office. Because these places customarily employ paid workers, and because their operation implies a certain amount of business management, it is sometimes felt that we may get bogged down with a heavy officialdom or, still worse, a downright professionalization of A.A. Though it must be said that these doubts are not always unreasonable, we have already had enough experience to relieve them in large part.

To begin with it seems most certain that we need never be overwhelmed by our clubs, local offices or by the General Office at New York City. These are places of service; they cannot really control or govern A.A. If any of them were to become inefficient or overbearing the remedy is simple enough. The average A.A. would stop his financial support until conditions were changed. As our *A.A. membership does not depend on fees or dues,* we can always "take our special facilities or leave them alone." These services must always serve us well or go out of business. Because no one is compelled to support them, they can never dictate, nor can they stray from the main body of A.A. tradition for very long.

In direct line with the principle of "taking our facilities or leaving them alone" there is an encouraging tendency to incorporate all such special functions separately if they involve any great amount of money, property or management. More and more, the A.A. groups are realizing that they are spiritual entities, not business organizations. Of course the smaller club rooms or meeting places often remain unincorporated because their business aspect is only nominal. But as large growth takes place it is usually found wise to incorporate and so set the club apart from surrounding groups. *Support of the club then becomes an individual matter rather than a group matter.* If, however, the

club also provides a central office secretary serving the surrounding area, it seems only fair that group treasuries in that area should shoulder this particular expense because such a secretary serves all groups, even though the club itself may not. Our evolution in large A.A. centers is beginning to indicate most clearly that while it is a proper function of a cluster of groups, or their central committee, to support a paid secretary for their area, it is not a group or central committee function to support clubs financially. Not all A.A.'s care for clubs. Therefore club support has to come mainly from those individual A.A.'s who need or like clubs, which, by the way, is the majority. But the majority ought not to try to coerce the minority into supporting clubs they do not want or need.

Of course clubs also get a certain amount of help from meetings held in them. Where central meetings for an area take place in a club it is customary to divide the collections between the club and the central committee for the area, heavily favoring the club of course, because the club is providing the meeting place. The same arrangement may be entered into between the club and any particular group which wishes to use the club whether for meeting or entertainment. Generally speaking, the board of directors of a club looks after the financial management and the social life of the place. But strictly A.A. matters remain the function of the surrounding groups themselves. This division of activity is by no means the rule everywhere: it is offered as a suggestion only, much in keeping, however, with the present trend.

A large club or central office usually means one or more paid workers. What about them—are they professionalizing A.A.? About this, there is a hot debate every time a club or central committee gets large enough to require paid help. On this subject we have all done a pile of fuzzy thinking. And I would be one of the first to plead guilty to that charge.

The reason for our fuzzy thinking is the usual one—it is fear. To each one of us, the ideal of A.A., however short we may be of it personally, is a thing of beauty and perfection. It is a power greater than ourselves which has lifted us out of the quicksand and set us safe on shore. The slightest thought of marring our ideal, much less bartering it for gold, is to most of us unthinkable. So we are constantly on the alert against the rise, within A.A., of a paid class of practitioners or missionaries. In A.A., where each of us is a goodwill prac-

titioner and missionary in his own right, there is no need for anyone to be paid for simple Twelfth Step work—a purely spiritual undertaking. While I suppose fear of any kind ought to be deplored, I must confess that I am rather glad that we exercise such great vigilance in this critical matter.

Yet there is a principle upon which I believe we can honestly solve our dilemma. It is this: a janitor can sweep the floor, a cook can boil the beef, a steward can eject a troublesome drunk, a secretary can manage an office, an editor can get out a newspaper—all, I am sure, without professionalizing A.A. If we didn't do these jobs ourselves we would have to hire nonalcoholics to do them for us. We would not ask any nonalcoholic to do these things full-time without pay. So why should some of us, who are earning good livings ourselves in the outside world, expect other A.A.'s to be full-time caretakers, cooks or secretaries? Why should these A.A.'s work for nothing at jobs which the rest of us could not or would not attempt ourselves? Or why, for that matter, should they be any the less well paid than for similar labor elsewhere? And what difference should it make if, in the course of their duties, they do some Twelfth Step work besides? Clearly the principle seems to be that we may pay well for special services—but never for straight Twelfth Step work.

How then, could A.A. be professionalized? Quite simply. I might, for example, hire an office and hang on the door a sign reading: "Bill W.—Alcoholics Anonymous Therapist. Charges $10.00 per hour." That would be face-to-face treatment of alcoholism for a fee. And I would surely be trading on the name of Alcoholics Anonymous, a purely amateur organization, to enlarge my professional practice. That *would* be professionalizing A.A.—and how! It would be quite legal, but hardly ethical.

Now does this mean we should criticize therapists as a class—even A.A.'s who might choose to go into that field? Not at all. The point is that no one ought to advertise himself as an *A.A.* therapist. As we are strictly amateur there can be no such thing. That would be a distortion of the facts which none of us could afford to try. As the tennis player has to drop his amateur status when he turns professional so should A.A.'s who become therapists cease publishing their A.A. connection. While I doubt if many A.A.'s ever go into the field of alcohol therapy, none ought to feel excluded, especially if they are trained social workers, psychologists or psychiatrists. But they certainly ought never to use their A.A. connection publicly or in such a way as to make people feel that A.A. has such a special class within its own ranks. That is where we all must draw the line.

To sum up—we have observed:

(a) That the use of money in A.A. is a matter of the gravest importance. Where its use ends and its misuse begins is the point we should vigilantly watch.

(b) That A.A. is already committed to a qualified use of money, because we would not think of abolishing our offices, meeting places and clubs simply for the sake of avoiding finances altogether.

(c) That our real problem today consists in setting intelligent and traditional limits upon our use of money, thus keeping its disruptive tendency at the minimum.

(d) That the voluntary contributions or pledges of A.A. members should be our principal and eventually our sole support; that this kind of self-support would always prevent our clubs and offices from getting out of hand, because their funds could readily be cut off whenever they failed to serve us well.

(e) That we have found it generally wise to separately incorporate those special facilities which require much money or management; that an A.A. group is a spiritual entity, not a business concern.

(f) That we must, at all costs, avoid the professionalization of A.A.; that simple Twelfth Step work is never to be paid for; that A.A.'s going into alcohol therapy should never trade on their A.A. connection; that there is not, and can never be, any such thing as an "A.A. therapist."

(g) That A.A. members may, however, be employed by us as full-time workers, provided they have legitimate duties over and beyond normal Twelfth Step work. We may, for example, surely engage secretaries, stewards and cooks without making them professional A.A.'s.

Continuing now the discussion of professionalism: A.A.'s frequently consult local committees or The Alcoholic Foundation* saying they have been offered positions in related fields. Hospitals want A.A. nurses and doctors, clinics ask for A.A.'s who

* Now known as The General Service Board of A.A., Inc.

are social workers, universities ask for A.A.'s to work in the field of alcohol education on a noncontroversial basis and industry wants us to recommend A.A.'s as personnel officers. Can we, acting as individuals, accept such offers? Most of us see no reason why we cannot.

It comes down to this. Have we A.A.'s the right to deny society the benefit of our special knowledge of the alcohol problem? Are we to tell society, even though we might make superior nurses, doctors, social workers or educators in the field of alcohol that we cannot undertake such missions for fear of professionalizing A.A.? That would certainly be farfetched, even ridiculous. Surely no A.A. should be barred from such employment because of his membership with us. He needs only to avoid "A.A. therapy" and any action or word which might hurt A.A. as a whole. Aside from this he ought to be just as employable as the nonalcoholic who would otherwise get the job and perhaps not do it half as well. In fact, I believe we still have a few A.A. bartenders. Though bartending, for obvious reasons, is not a specially recommended occupation, I have never heard anyone point out that these few members are professionalizing A.A. on account of their very special knowledge of barrooms!

Years ago we used to think A.A. should have its own hospitals, rest homes and farms. Nowadays we are equally convinced we should have nothing of the sort. Even our clubs, well inside A.A., are somewhat set apart. And in the judgment of practically all, places of hospitalization or rest should be well *outside* A.A.—and medically supervised. Hospitalization is most definitely the job of the doctor, backed, of course, by private or community aid. It is not a function of A.A. in the sense of management or ownership. Everywhere we cooperate with hospitals. Many afford us special privileges and working arrangements. Some consult us. Others employ A.A. nurses or attendants. Relationships such as these almost always work well. But none of these institutions are known as "A.A. hospitals."

Now what about donations or payments to A.A. from outside sources? There was a time some years ago when we desperately needed a little outside aid. This we received. And we shall never cease being grateful to these devoted friends whose contributions made possible The Alcoholic Foundation, the book "Alcoholics Anonymous" and our General Office. Heaven has surely reserved a special place for every one of them. They met a great need, for in those days we A.A.'s were very few and very insolvent!

But times have changed. Alcoholics Anonymous now has thousands* of members whose combined earnings each year amount to untold millions of dollars. Hence a very powerful feeling is spreading among us that A.A. ought to be self-supporting. Since most members feel they owe their very lives to the movement, they think we A.A.'s ought to pay its very modest expenses. And isn't it high time, they ask, that we commence to revise the prevalent idea that an alcoholic is *always* a person who must be helped—usually with money? Let us A.A.'s, they say, be no longer takers from society. Instead let us be givers. We are not helpless now. Neither are we penniless any more. Were it possible to publish tomorrow that every A.A. group has become fully self-supporting, it is probable that nothing could create more goodwill for us than such a declaration. Let our generous public devote its funds to alcohol research, hospitalization or education. These fields really need money. But we do not. We are no longer poor. We can, and we should, pay our own way.

Of course, it can hardly be counted an exception to the principle of self-support if a nonalcoholic friend comes to a meeting and drops a dollar in the hat.

But it is not these small tokens of regard which concern us. It is the large contributions, especially those that may carry future obligations, which should give us pause. Then too, there is evidence that wealthy people are setting aside sums for A.A. in their wills under the impression we could use a great deal of money if we had it. Shouldn't we discourage them? And already there have been a few alarming attempts at the public solicitation of money in the name of Alcoholics Anonymous. Few A.A.'s will fail to imagine where such a course would lead us. Every now and then we are offered money from so-called "wet" or "dry" sources. Obviously dangerous, this. For we must stay out of that ill-starred controversy. Now and then the parents of an alcoholic, out of sheer gratitude, wish to donate heavily. Is this wise? Would it be good for the alcoholic himself? Perhaps a wealthy A.A. wishes to make a large gift. Would it be good for him, or for us, if he did so? Might we not feel in his debt and might he not, especially if a newcomer, begin to think he had

* Estimated membership in 1974: 725,000.

bought a ticket to a happy destination, sobriety?

In no case have we ever been able to question the true generosity of these givers. But is it wise to take their gifts? Although there may be rare exceptions, I share the opinion of most older A.A.'s that acceptance of large donations from any source whatever is very questionable and almost always a hazardous policy. True, the struggling club may badly need a friendly gift or loan. Even so, it might be better in the long run to pay as we go. We must never let any immediate advantage, however attractive, blind us to the possibility that we may be creating a disastrous precedent for the future. Strife over money and property has too often wrecked better societies than we temperamental alcoholics!

It is with the deepest gratitude and satisfaction that I can now tell you of a recent resolution passed by our over-all service committee, the trustees of The Alcoholic Foundation, who are the custodians of our national A.A. funds. As a matter of policy, they have just gone on record that they will decline all gifts carrying the slightest obligation, expressed or implied. And further, that The Alcoholic Foundation will accept no earnings which may be tendered from any commercial source. As most readers know, we have been approached of late by several motion picture concerns about the possibility of an A.A. film. Naturally money has been discussed. But our trustees, very rightly I think, take the position that A.A. has nothing to sell; that we all wish to avoid even the suggestion of commerce, and that in any case A.A., generally speaking, is now self-supporting.

To my mind, this is a decision of enormous importance to our future—a very long step in the right direction. When such an attitude about money becomes universal through A.A., we shall have finally steered clear of that golden, alluring, but very treacherous reef called Materialism.

In the years that lie just ahead Alcoholics Anonymous faces a supreme test—the great ordeal of its own prosperity and success. I think it will prove the greatest trial of all. Can we but weather that, the waves of time and circumstances may beat upon us in vain. Our destiny will be secure!

A.A.'s Position in the Field of Alcoholism

(This statement of A.A.'s policies in relation to the public and to other organizations has been affirmed and reaffirmed by the General Service Conference. It appears also in "How A.A. Members Cooperate," a useful pamphlet on the application of our Traditions to A.A. life.)

ALCOHOLICS ANONYMOUS *is a worldwide fellowship of men and women who help each other to maintain sobriety and who offer to share their recovery experience freely with others who may have a drinking problem. The A.A. program consists basically of Twelve Steps designed for personal recovery from alcoholism.*

THE FELLOWSHIP *functions through more than 22,000 local groups in 92 countries. Hundreds of thousands of alcoholics have achieved sobriety in A.A., but members recognize that their program is not always effective with all alcoholics and that some may require professional counseling or treatment.*

A.A. IS CONCERNED *solely with the personal recovery and continued sobriety of individual alcoholics who turn to the Fellowship for help. The movement does not engage in the field of alcoholism research, or medical or psychiatric treatment, and does not endorse any causes—although A.A. members often participate in other activities as individuals.*

THE MOVEMENT *has adopted a policy of "cooperation but nonaffiliation" with other organizations concerned with the problem of alcoholism.*

ALCOHOLICS ANONYMOUS *is self-supporting through its own groups and members and declines contributions from outside sources. A.A. members preserve personal anonymity at the level of press, films and broadcast media.*

WILL A.A. EVER HAVE A PERSONAL GOVERNMENT?

—1947*—

(Today Tradition Nine says: A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.)

The answer to this question is almost surely "no." That is the clear verdict of our experience.

To begin with, each A.A. has been an individual who, because of his alcoholism, could seldom govern himself. Nor could any other human being govern the alcoholic's obsession to drink, his drive to have things his own way. Time out of mind, families, friends, employers, doctors, clergymen, and judges have tried their hand at disciplining alcoholics. Almost without exception the failure to accomplish anything by coercion has been complete. Yet we alcoholics can be led, we can be inspired: coming into A.A. we can, and we gladly do, yield to the will of God. Hence it is not strange that the only real authority to be found in A.A. is that of spiritual principle. It is never personal authority.

Our unreasonable individualism (egocentricity if you like) was, of course, the main reason we all failed in life and betook ourselves to alcohol. When we couldn't coerce others into conformity with our own plans and desires, we drank. When others tried to coerce us, we also drank. Though now sober, we still have a strong hangover of these early traits which caused us to resist authority. Therein probably hangs a clue to our lack of personal government in A.A.: no fees, no dues, no rules and regulations, no demand that alcoholics conform to A.A. principles, no one set in personal authority over anyone else. Though no sterling virtue, our aversion to obedience does pretty well guarantee us freedom from personal domination of any kind.

Still it is a fact that most of us do follow, in our personal lives, the Twelve *Suggested* Steps to recovery. But we do this from choice. We prefer recovery to death. Then, little by little, we perceive the spiritual basis of life is the best. We conform because we want to.

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* Originally published in The A.A. Grapevine.

Likewise, most A.A. groups become willing to follow the "Twelve Points of Tradition to Assure Our Future." The groups are willing to avoid controversy over outside issues such as political reform or religion; they stick to their single purpose of helping alcoholics to recover; they increasingly rely on self-support rather than outside charity. More and more do they insist on modesty and anonymity in their public relations. The A.A. groups follow these other traditional principles for the very same reason that the individual A.A. follows the Twelve Steps to recovery. Groups see they would disintegrate if they didn't and they soon discover that adherence to our tradition and experience is the foundation for a happier and more effective group life.

Nowhere in A.A. is there to be seen any constituted human authority that can compel an A.A. group to do anything. Some A.A. groups, for example, elect their leaders. But even with such a mandate each leader soon discovers that while he can always guide by example or persuasion he can never boss, else at election time he may find himself passed by.

The majority of A.A. groups do not even choose leaders. They prefer rotating committees to handle their simple affairs. These committees are invariably regarded as servants—they have only the authorization to serve, never to command. Each committee carries out what it believes to be the wishes of its group. That is all. Though A.A. committees used to try to discipline wayward members, though they have sometimes composed minute rules and regulations and now and then have set themselves up as judges of other people's personal morals, I know of no case where any of these seemingly worthy strivings had any lasting effect—except, perhaps, the election of a brand-new committee!

Surely I can make these assertions with the greatest of confidence. For in my own turn I, too, have tried a hand at governing A.A. Each time I have strenuously tried it I have been shouted down.

After struggling a few years to run the A.A. movement I had to give it up—it simply didn't work. Heavy-handed assertion of my personal authority always created confusion and resistance. If I took sides in a controversy, I was joyfully quoted by some, while others murmured, "And just who does this dictator think he is?" If I sharply criticized, I usually got double criticism

on the return bounce. Personal power always failed. I can see my older A.A. friends smiling. They are recalling those times when they, too, felt a mighty call to "save the A.A. movement" from something or other. But their days of playing "Pharisee" are now over. So those little maxims "Easy Does It" and "Live and Let Live" have come to be deeply meaningful and significant to them and to me. In such fashion each of us learns that, in A.A., one can be a servant only.

Here at the General Office we have long known that we can merely supply certain indispensable services. We can supply information and literature; we can usually tell how the majority of A.A.'s feel about our current problems; we can assist new groups to start, giving advice if asked; we can look after the over-all A.A. public relations; we can sometimes mediate difficulties. Similarly, the editors of our monthly journal, The A.A. Grapevine, believe themselves simply a mirror of current A.A. life and thought. Serving purely as such, they cannot rule or propagandize. So. also, the trustees of The Alcoholic Foundation (our A.A. general service committee) know themselves to be simple custodians, custodians who guarantee the effectiveness of the A.A. General Office and The A.A. Grapevine and who are the repository of our general funds and Traditions—caretakers only.

It is most clearly apparent that, even here at the very center of A.A., there can only exist a center of service—custodians, editors, secretaries and the like—each, to be sure, with a special vital function, but none of them with any authority to govern Alcoholics Anonymous.

That such centers of service, international, national, metropolitan area or local, will be sufficient for the future, I can have no doubt. So long as we avoid any menacing accumulation of wealth or the growth of personal government at these centers, we cannot go astray. While wealth and authority lie at the foundation of many a noble institution, we of A.A. now apprehend, and thoroughly well, that these things are not for us. Have we not found that one man's meat is often another man's poison?

Shall we not do well if, instead, we can cling in some part to the brotherly ideals of the early Franciscans? Let all of us A.A.'s, whether we be trustees, editors, secretaries, janitors or cooks—or just members—ever recall the unimportance of wealth and authority as compared with the vast import of our brotherhood, love and service.

ANONYMITY

—1946*—

(One of the first articles on our vital Anonymity Traditions)

In the years that lie ahead the principle of anonymity will undoubtedly become a part of our vital tradition. Even today we sense its practical value. But more important still, we are beginning to feel that the word "anonymous" has for us an immense spiritual significance. Subtly but powerfully it reminds us that we are always to place principles before personalities; that we have renounced personal glorification in public; that our movement not only preaches but actually practices a true humility. That the practice of anonymity in our public relations has already had a profound effect upon us, and upon our millions of friends in the outside world, there can hardly be doubt. Anonymity is already a cornerstone of our public relations policy.

How this idea first originated and subsequently took hold of us is an interesting bit of A.A. history. In the years before the publication of the book "Alcoholics Anonymous," we had no name. Nameless, formless, our essential principles of recovery still under debate and test, we were just a group of drinkers groping our way along what we hoped would be the road to freedom. Once we became sure that our feet were set on the right track we decided upon a book in which we could tell other alcoholics the good news. As the book took form we inscribed in it the essence of our experience. It was the product of thousands of hours of discussion. It truly represented the collective voice, heart and conscience of those of us who had pioneered the first four years of A.A.

As the day of publication approached we racked our brains to find a suitable name for the volume. We must have considered at least two hundred titles. Thinking up titles and voting upon them at meetings became one of our main activities. A great welter of discussion and argument finally narrowed our choice to a single pair of names. Should we call our new book "The Way Out" or should we call it "Alcoholics Anonymous"? That was the final question. A last-minute vote was taken by the Akron and New York Groups. By a narrow majority the verdict was for naming our

* Originally published in The A.A. Grapevine.

book "The Way Out." Just before we went to print somebody suggested there might be other books having the same title. One of our early lone members (dear old Fitz M., who then lived in Washington) went over to the Library of Congress to investigate. He found exactly twelve books already titled "The Way Out." When this information was passed around, we shivered at the possibility of being the "Thirteenth Way Out." So "Alcoholics Anonymous" became first choice. That's how we got a name for our book of experience, a name for our movement and, as we are now beginning to see, a tradition of the greatest spiritual import. God does move in mysterious ways His wonders to perform!

In the book "Alcoholics Anonymous" there are only three references to the principle of anonymity. The foreword of our first edition states: "Being mostly business or professional folk some of us could not carry on our occupations if known" and "When writing or speaking publicly about alcoholism, we urge each of our Fellowship to omit his personal name, designating himself instead as 'a member of Alcoholics Anonymous,'" and then, "very earnestly we ask the press also to observe this request for otherwise we shall be greatly handicapped."

Since the publication of "Alcoholics Anonymous" in 1939 hundreds of A.A. groups have been formed. Every one of them asks these questions: "Just how anonymous are we supposed to be?" and "After all, what good is this principle of anonymity anyway?" To a great extent each group has settled upon its own interpretation. Naturally enough wide differences of opinion remain among us. Just what our anonymity means and just how far it ought to go are unsettled questions.

Though we no longer fear the stigma of alcoholism as we once did, we still find individuals who are extremely sensitive about their connection with us. A few come in under assumed names. Others swear us to the deepest secrecy. They fear their connection with Alcoholics Anonymous may ruin their business or social position. At the other end of the scale of opinion we have the individual who declares that anonymity is a lot of childish nonsense. He feels it his bounden duty to cry his membership in Alcoholics Anonymous from the housetops. He points out that our A.A. Fellowship contains people of renown, some of national importance. Why, he asks, shouldn't we capitalize on their personal prestige just as any other organization would?

In between these extremes the shades of opinion are legion. Some groups, especially newer ones, conduct themselves like secret societies. They do not wish their activities known even to friends. Nor do they propose to have preachers, doctors, or even their wives at any of their meetings. As for inviting in newspaper reporters—perish the thought!

Other groups feel that their communities should know all about Alcoholics Anonymous. Though they print no names, they do seize every opportunity to advertise the activities of their group. They occasionally hold public or semipublic meetings where A.A.'s appear on the platform by name. Doctors, clergymen and public officials are frequently invited to speak at such gatherings. Here and there a few A.A.'s have dropped their anonymity completely. Their names, pictures and personal activities have appeared in the public print. As A.A.'s they have sometimes signed their names to articles telling of their membership.

So while it is quite evident that most of us believe in anonymity, our practice of the principle does vary a great deal. And, indeed, we must realize that the future safety and effectiveness of Alcoholics Anonymous may depend upon its preservation.

The vital question is: Just where shall we fix this point where personalities fade out and anonymity begins?

As a matter of fact, few of us are anonymous so far as our daily contacts go. We have dropped anonymity at this level because we think our friends and associates ought to know about Alcoholics Anonymous and what it has done for us. We also wish to lose the fear of admitting that we are alcoholics. Though we earnestly request reporters not to disclose our identities, we frequently speak before semipublic gatherings under our right names. We wish to impress audiences that our alcoholism is a sickness we no longer fear to discuss before anyone. So far, so good.

If, however, we venture beyond this limit we shall surely lose the principle of anonymity forever. If every A.A. felt free to publish his own name, picture and story we would soon be launched upon a vast orgy of personal publicity which obviously could have no limit whatever. Isn't this where, by the strongest kind of tradition, we must draw the line?

1. Therefore, it should be the privilege of each A.A. to cloak himself with as much personal

anonymity as he desires. His fellow A.A.'s should respect his wishes and help guard whatever status he wants to assume.

2. Conversely, the individual A.A. ought to respect the feeling of his local group about anonymity. If members of his group wish to be less conspicuous in their locality than he does, he ought to go along with them unless they change their views.

3. It ought to be a worldwide policy that no member of Alcoholics Anonymous shall ever feel free to publish, in connection with any A.A. activity, his name or picture in mediums of public circulation. This would not, however, restrict the use of his name in other public activities provided, of course, he does not disclose his A.A. membership.

If these suggestions, or variations of them, are to be adopted as a general policy, every A.A. will want to know more about our experience so far. He will surely wish to know how most of our older members are thinking on the subject of anonymity at the present time. It will be the purpose of this piece to bring everybody up-to-date on our collective experience.

Firstly, I believe most of us would agree that the general idea of anonymity is sound, because it encourages alcoholics and the families of alcoholics to approach us for help. Still fearful of being stigmatized, they regard our anonymity as an assurance their problems will be kept confidential; that the alcoholic skeleton in the family closet will not wander in the streets.

Secondly, the policy of anonymity is a protection to our cause. It prevents our founders or leaders, so-called, from becoming household names who might at any time get drunk and give A.A. a black eye. No one need say that couldn't happen here. It could.

Thirdly, almost every newspaper reporter who covers us complains, at first, of the difficulty of writing his story without names. But he quickly forgets this difficulty when he realizes that here is a group of people who care nothing for personal gain. Probably it is the first time in his life he has ever reported an organization which wants no personal publicity. Cynic though he may be, this obvious sincerity instantly transforms him into a friend of A.A. Therefore his piece is a friendly piece, never a routine job. It is enthusiastic writing because the reporter feels that way himself.

People often ask how Alcoholics Anonymous has been able to secure such an incredible amount of excellent publicity. The answer seems to be that practically everyone who writes about us becomes an A.A. convert, sometimes a zealot. Is not our policy of anonymity mainly responsible for this phenomenon?

Fourthly, why does the general public regard us so favorably? Is it simply because we are bringing recovery to lots of alcoholics? No, this can hardly be the whole story. However impressed he may be by our recoveries, John Q. Public is even more interested in our way of life. Weary of pressure selling, spectacular promotion and shouting public characters, he is refreshed by our quietness, modesty and anonymity. It well may be that he feels a great spiritual power is being generated on this account—that something new has come into his own life.

If anonymity has already done these things for us, we surely ought to continue it as a general policy. So very valuable to us now, it may become an incalculable asset for the future. *In a spiritual sense, anonymity amounts to the renunciation of personal prestige as an instrument of general policy.* I am confident that we shall do well to preserve this powerful principle; that we should resolve never to let go of it.

Now what about its application? Since we advertise anonymity to every newcomer, we ought, of course, to preserve a new member's anonymity so long as he wishes it preserved—because, when he read our publicity and came to us, we contracted to do exactly that. And even if he wants to come in under an assumed name, we should assure him he can. If he wishes us to refrain from discussing his case with anyone, even other A.A. members, we ought to respect that wish too. While most newcomers do not care a rap who knows about their alcoholism, there are others who care very much. Let us guard them in every way until they get over that feeling.

Then comes the problem of the newcomer who wishes to drop his anonymity too fast. He rushes to all his friends with the glad news of A.A. If his group does not caution him he may rush to a newspaper office or a microphone to tell the wide world all about himself. He is also likely to tell everyone the innermost details of his personal life, soon to find that, in this respect, he has altogether too much publicity! We ought to suggest to him that he take things easy; that he first get on his own feet before talking about A.A.

to all and sundry; that no one thinks of publicizing A.A. without being sure of the approval of his own group.

Then there is the problem of group anonymity. Like the individual, it is probable that the group ought to feel its way along cautiously until it gains strength and experience. There should not be too much haste to bring in outsiders or to set up public meetings. Yet this early conservatism can be overdone. Some groups go on, year after year, shunning all publicity or any meetings except those for alcoholics only. Such groups are apt to grow slowly. They become stale because they are not taking in fresh blood fast enough. In their anxiety to maintain secrecy they forget their obligation to other alcoholics in their communities who have not heard that A.A. has come to town. But this unreasonable caution eventually breaks down. Little by little some meetings are opened to families and close friends. Clergymen and doctors may now and then be invited. Finally the group enlists the aid of the local newspaper.

In most places, but not all, it is customary for A.A.'s to use their own names when speaking before public or semipublic gatherings. This is done to impress audiences that we no longer fear the stigma of alcoholism. If, however, newspaper reporters are present they are earnestly requested not to use the names of any of the alcoholic speakers on the program. This preserves the principle of anonymity so far as the general public is concerned and at the same time represents us as a group of alcoholics who no longer fear to let our friends know that we have been very sick people.

In practice then, the principle of anonymity seems to come down to this: with one very important exception, the question of how far each individual or group shall go in dropping anonymity is left strictly to the individual or group concerned. The exception is: that all groups or individuals, when writing or speaking for publication as members of Alcoholics Anonymous, feel bound never to disclose their true names. It is at this point of publication that we feel we should draw the line on anonymity. *We ought not disclose ourselves to the general public through the media of the press, in pictures or on the radio.*

Any who would drop their anonymity must reflect that they may set a precedent which could eventually destroy a valuable principle. We must never let any immediate advantage shake us in our determination to keep intact such a really vital tradition.

Great modesty and humility are needed by every A.A. for his own permanent recovery. If these virtues are such vital needs to the individual, so must they be to A.A. as a whole. This principle of anonymity before the general public can, if we take it seriously enough, guarantee the Alcoholics Anonymous movement these sterling attributes forever. Our public relations policy should mainly rest upon the principle of attraction and seldom, if ever, upon promotion.

WHY ALCOHOLICS ANONYMOUS IS ANONYMOUS

—1955*—

As never before, the struggle for power, importance and wealth is tearing civilization apart. Man against man, family against family, group against group, nation against nation.

Nearly all those engaged in this fierce competition declare that their aim is peace and justice for themselves, their neighbors and their nations . . . give us power and we shall have justice; give us fame and we shall set a great example; give us money and we shall be comfortable and happy. People throughout the world deeply believe that, and act accordingly. On this appalling dry bender, society seems to be staggering down a dead-end road. The stop sign is clearly marked. It says "Disaster."

What has this got to do with anonymity, and Alcoholics Anonymous?

(How Bill W. felt about anonymity 20 years after A.A. was formed)

* Originally published in The A.A. Grapevine.

We of A.A. ought to know. Nearly every one of us has traversed this identical dead-end path. Powered by alcohol and self-justification, many of us have pursued the phantoms of self-importance and money right up to the disaster stop sign. Then came A.A. We faced about and found ourselves on a new highroad where the direction signs said never a word about power, fame or wealth. The new signs read, "This way to sanity and serenity—the price is self-sacrifice."

Our new book, "Twelve Steps and Twelve Traditions," states that "Anonymity is the greatest protection our Society can ever have." It says also that "The spiritual substance of anonymity is sacrifice."

Let's turn to A.A.'s twenty years of experience and see how we arrived at that belief, now expressed in our Traditions Eleven and Twelve.

At the beginning we sacrificed alcohol. We had to, or it would have killed us. But we couldn't get rid of alcohol unless we made other sacrifices. Big shot-ism and phony thinking had to go. We had to toss self-justification, self-pity, and anger right out the window. We had to quit the crazy contest for personal prestige and big bank balances. We had to take personal responsibility for our sorry state and quit blaming others for it.

Were these sacrifices? Yes, they were. To gain enough humility and self-respect to stay alive at all we had to give up what had really been our dearest possession—our ambitions and our illegitimate pride.

But even this was not enough. Sacrifice had to go much further. Other people had to benefit too. So we took on some Twelfth Step work; we began to carry the A.A. message. We sacrificed time, energy and our own money to do this. We couldn't keep what we had unless we gave it away.

Did we demand that our new prospects give us anything? Were we asking them for power over their lives, for fame for our good work or for a cent of their money? No, we were not. We found that if we demanded any of these things our Twelfth Step work went flat. So these natural desires had to be sacrificed; otherwise, our prospects received little or no sobriety. Nor, indeed, did we.

Thus we learned that sacrifice had to bring a double benefit, or else little at all. We began to know about the kind of giving of ourselves that had no price tag on it.

When the first A.A. group took form, we soon learned a lot more of this. We found that each of us had to make willing sacrifices for the group itself, sacrifices for the common welfare. The group, in turn, found that it had to give up many of its own rights for the protection and welfare of each member, and for A.A. as a whole. These sacrifices had to be made or A.A. couldn't continue to exist.

Out of these experiences and realizations, the Twelve Traditions of Alcoholics Anonymous began to take shape and substance.

Gradually we saw that the unity, the effectiveness—yes, even the survival—of A.A. would always depend upon our continued willingness to sacrifice our personal ambitions and desires for the common safety and welfare. Just as sacrifice meant survival for the individual, so did sacrifice mean unity and survival for the group and for A.A.'s entire Fellowship.

Viewed in this light, A.A.'s Twelve Traditions are little else than a list of sacrifices which the experience of twenty years has taught us that we must make, individually and collectively, if A.A. itself is to stay alive and healthy.

In our Twelve Traditions we have set our faces against nearly every trend in the outside world.

We have denied ourselves personal government, professionalism and the right to say who our members shall be. We have abandoned do-good-ism, reform and paternalism. We refuse charitable money and prefer to pay our own way. We will cooperate with practically everybody, yet we decline to marry our Society to anyone. We abstain from public controversy and will not quarrel among ourselves about those things that so rip society asunder—religion, politics and reform. We have but one purpose: to carry the A.A. message to the sick alcoholic who wants it.

We take these attitudes not at all because we claim special virtue or wisdom; we do these things because hard experience has told us that we must—if A.A. is to survive in the distraught world of today. We also give up rights and make sacrifices because we ought to—and, better yet, because we want to. A.A. is a power greater than any of us; it must go on living or else uncounted thousands of our kind will surely die. This we know.

Now where does anonymity fit into this pic-

ture? What is anonymity anyhow? Why do we think it is the greatest single protection that A.A. can ever have? Why is it our greatest symbol of personal sacrifice, the spiritual key to all our Traditions and to our whole way of life?

The following fragment of A.A. history will reveal, I deeply hope, the answer we all seek.

Years ago a noted ballplayer sobered up through A.A. Because his comeback was so spectacular, he got a tremendous personal ovation in the press and Alcoholics Anonymous got much of the credit. His full name and picture, as a member of A.A., were seen by millions of fans. It did us plenty of good; alcoholics flocked in. We loved this. I was specially excited because it gave me ideas.

Soon I was on the road, happily handing out personal interviews and pictures. To my delight, I found I could hit the front pages, just as he could. Besides, he couldn't hold his publicity pace, but I could hold mine. I only needed to keep traveling and talking. The local A.A. groups and newspapers did the rest. I was astonished when recently I looked at those old newspaper stories. For two or three years I guess I was A.A.'s number one anonymity-breaker.

So I can't blame any A.A. who has grabbed the spotlight since. I set the main example myself, years ago.

At the time, this looked like the thing to do. Thus justified, I ate it up. What a bang it gave me when I read those two-column spreads about "Bill the Broker," full name and picture, the guy who was saving drunks by the thousands!

Then this fair sky began to be a little overcast. Murmurs were heard from A.A. skeptics who said, "This guy Bill is hogging the big time. Dr. Bob isn't getting his share." Or, again, "Suppose all this publicity goes to Bill's head and he gets drunk on us?"

This stung. How could they persecute me when I was doing so much good? I told my critics that this was America and didn't they know I had the right of free speech? And wasn't this country and every other run by big-name leaders? Anonymity was maybe okay for the average A.A. But co-founders ought to be exceptions. The public certainly had a right to know who *we* were.

Real A.A. power-drivers (prestige-hungry people, folks just like me) weren't long in catching on. They were going to be exceptions too. They

said that anonymity before the general public was just for timid people: all the braver and bolder souls, like themselves, should stand right up before the flashbulbs and be counted. This kind of courage would soon do away with the stigma on alcoholics. The public would right away see what fine citizens recovered drunks could make. So more and more members broke their anonymity, all for the good of A.A. What if a drunk *was* photographed with the Governor? Both he and the Governor deserved the honor, didn't they? Thus we zoomed along, down the dead-end road!

The next anonymity-breaking development looked even rosier. A close A.A. friend of mine wanted to go in for alcohol education. A department of a great university interested in alcoholism wanted her to go out and tell the general public that alcoholics were sick people, and that plenty could be done about it. My friend was a crack public speaker and writer. Could she tell the general public that she was an A.A. member? Well, why not? By using the name Alcoholics Anonymous she'd get fine publicity for a good brand of alcohol education and for A.A. too. I thought it an excellent idea and therefore gave my blessing.

A.A. was already getting to be a famous and valuable name. Backed by our name and her own great ability, the results were immediate. In nothing flat her own full name and picture, plus excellent accounts of her educational project, and of A.A., landed in nearly every large paper in North America. The public understanding of alcoholism increased, the stigma on drunks lessened, and A.A. got new members. Surely there could be nothing wrong with that.

But there was. For the sake of this short-term benefit, we were taking on a future liability of huge and menacing proportions.

Presently an A.A. member began to publish a crusading magazine devoted to the cause of Prohibition. He thought Alcoholics Anonymous ought to help make the world bone-dry. He disclosed himself as an A.A. member and freely used the A.A. name to attack the evils of whiskey and those who made it and drank it. He pointed out that he too was an "educator," and that his brand of education was the "right kind." As for putting A.A. into public controversy, he thought that was exactly where we should be. So he busily used A.A.'s name to do just that. Of course, he broke his anonymity to help his cherished cause along.

That was followed by a proposal from a liquor-trade association that an A.A. member take on a job of "education." People were to be told that too much alcohol was bad for anyone and that certain people—the alcoholics—shouldn't drink at all. What could be the matter with this?

The catch was that our A.A. friend had to break his anonymity; every piece of publicity and literature was to carry his full name as a member of Alcoholics Anonymous. This of course would be bound to create the definite public impression that A.A. favored "education," liquor-trade style.

Though these two developments never happened to get far, their implications were nevertheless terrific. They spelled it right out for us. By hiring out to another cause, and then declaring his A.A. membership to the whole public, it was in the power of an A.A. to marry Alcoholics Anonymous to practically any enterprise or controversy at all, good or bad. The more valuable the A.A. name became, the greater the temptation would be.

Further proof of this was not long in showing up. Another member started to put us into the advertising business. He had been commissioned by a life insurance company to deliver a series of twelve "lectures" on Alcoholics Anonymous over a national radio hookup. This would of course advertise life insurance and Alcoholics Anonymous—*and naturally our friend himself*—all in one good-looking package.

At A.A. Headquarters, we read the proposed lectures. They were about 50% A.A. and 50% our friend's personal religious convictions. This could create a false public view of us. Religious prejudice against A.A. would be aroused. So we objected.

Our friend shot back a hot letter saying that he felt "inspired" to give these lectures, and that we had no business to interfere with his right of free speech. Even though he was going to get a fee for his work, he had nothing in mind except the welfare of A.A. And if we didn't know what was good for us, that was too bad! We and A.A.'s Board of Trustees could go plumb to the devil. The lectures were going on the air.

This was a poser. Just by breaking anonymity and so using the A.A. name for his own purposes, our friend could take over our public relations, get us into religious trouble, put us into the advertising business and, for all these good works, the insurance company would pay him a handsome fee.

Did this mean that any misguided member could thus endanger our Society any time or any place simply by breaking anonymity and telling himself how much good he was going to do for us? We envisioned every A.A. advertising man looking up a commercial sponsor, using the A.A. name to sell everything from pretzels to prune juice.

Something had to be done. We wrote our friend that A.A. had a right to free speech too. We wouldn't oppose him publicly, but we could and would guarantee that his sponsor would receive several thousand letters of objection from A.A. members if the program went on the radio. Our friend abandoned the project.

But our anonymity dike continued to leak. A.A. members began to take us into politics. They began to tell state legislative committees—publicly, of course—just what A.A. wanted in the way of rehabilitation, money and enlightened legislation.

Thus, by full name and often by pictures, some of us became lobbyists. Other members sat on benches with police court judges, advising which drunks in the lineup should go to A.A. and which to jail.

Then came money complications involving broken anonymity. By this time, most members felt we ought to stop soliciting funds publicly for A.A. purposes. But the educational enterprise of my university-sponsored friend had meanwhile mushroomed. She had a perfectly proper and legitimate need for money and plenty of it. Therefore, she asked the public for it, putting on drives to this end. Since she was an A.A. member and continued to say so, many contributors were confused. They thought A.A. was in the educational field or else they thought A.A. itself was raising money when indeed it was not and didn't want to.

So A.A.'s name was used to solicit funds at the very moment we were trying to tell people that A.A. wanted no outside money.

Seeing what happened, my friend, wonderful member that she is, tried to resume her anonymity. Because she had been so thoroughly publicized, this has been a hard job. It has taken her years. But she has made the sacrifice, and I here want to record my deep thanks on behalf of us all.

This precedent set in motion all sorts of public solicitations by A.A.'s for money—money for drying-out farms, Twelfth Step enterprises, A.A.

boardinghouses, clubs, and the like—powered largely by anonymity-breaking.

We were next startled to learn that we had been drawn into partisan politics, this time for the benefit of a single individual. Running for public office, a member splashed his political advertising with the fact that he was an A.A. and, by inference, sober as a judge! A.A. being popular in his state, he thought it would help him win on election day.

Probably the best story in this class tells how the A.A. name was used to back up a libel lawsuit. A member, whose name and professional attainments are known on three continents, got hold of a letter which she thought damaged her professional reputation. She felt something should be done about this and so did her lawyer, also an A.A. They assumed that both the public and A.A. would be rightfully angry if the facts were known. Forthwith, several newspapers headlined how Alcoholics Anonymous was rooting for one of its lady members—name in full, of course—to win her suit for libel. Shortly after this, a noted radio commentator told a listening audience, estimated at twelve million people, the same thing. This again proved that the A.A. name could be used for purely personal purposes . . . this time on a nationwide scale.

The old files at A.A. Headquarters reveal many scores of such experiences with broken anonymity. Most of them point up the same lessons.

They tell us that we alcoholics are the biggest rationalizers in the world; that fortified with the excuse we are doing great things for A.A. we can, through broken anonymity, resume our old and disastrous pursuit of personal power and prestige, public honors, and money—the same implacable urges that when frustrated once caused us to drink; the same forces that are today ripping the globe apart at its seams. Moreover, they make clear that enough spectacular anonymity-breakers could someday carry our whole Society down into that ruinous dead end with them.

So we are certain that if such forces ever rule our Fellowship, we will perish too, just as other societies have perished throughout human history. Let us not suppose for a moment that we recovered alcoholics are so much better or stronger than other folks; or that, because in twenty years nothing has ever happened to A.A., nothing ever can.

Our really great hope lies in the fact that our

total experience, as alcoholics and as A.A. members, has at last taught us the immense power of these forces for self-destruction. These hard-won lessons have made us entirely willing to undertake every personal sacrifice necessary for the preservation of our treasured Fellowship.

This is why we see anonymity *at the general public level* as our chief protection against ourselves, the guardian of all our Traditions and the greatest symbol of self-sacrifice that we know.

Of course no A.A. need be anonymous to family, friends, or neighbors. Disclosure there is usually right and good. Nor is there any special danger when we speak at group or semipublic A.A. meetings, provided press reports *reveal first names only.*

But before the general public—press, radio, films, television and the like—the revelation of full names and pictures is the point of peril. This is the main escape hatch for the fearful destructive forces that still lie latent in us all. Here the lid can and must stay down.

We now fully realize that 100% personal anonymity before the public is just as vital to the life of A.A. as 100% sobriety is to the life of each and every member.

I say all this with what earnestness I can; I say this because I know what the temptation of fame and money really is. I can say this because I was once a breaker of anonymity myself. I thank God that years ago the voice of experience and the urging of wise friends took me out of the perilous path into which I might have led our entire Society. Thus I learned that the temporary or seeming good can often be the deadly enemy of the permanent best. When it comes to survival for A.A., nothing short of our very best will be good enough.

We want to maintain 100% anonymity for still another potent reason, one often overlooked. Instead of securing us more publicity, repeated self-serving anonymity breaks could severely damage the wonderful relation we now enjoy with press and public alike. We could wind up with a poor press and little public confidence at all.

For many years, news channels all over the world have showered A.A. with enthusiastic publicity, a never-ending stream of it, far out of proportion to the news values involved. Editors tell us why this is. They give us extra space and time because their confidence in A.A. is complete. The very foundation of that high confidence is, they

say, our continual insistence on personal anonymity at the press level.

Never before had news outlets and public relations experts heard of a society that absolutely refused personally to advertise its leaders or members. To them, this strange and refreshing novelty has always been proof positive that A.A. is on the square; that nobody has an angle.

This, they tell us, is the prime reason for their great goodwill. This is why, in season and out, they continue to carry the A.A. message of recovery to the whole world.

If, through enough anonymity lapses, we finally caused the press, the public and our alcoholic prospects themselves to wonder about our motives, we'd surely lose this priceless asset and, along with it, countless prospective members.

For a long time now, both Dr. Bob and I have done everything possible to maintain the Tradition of anonymity. Just before he died, some of Dr. Bob's friends suggested that there should be a suitable monument or mausoleum erected in honor of him and his wife, Anne, something befitting a founder. Dr. Bob declined, with thanks. Telling me about this a little later, he grinned and said, "For heaven's sake, Bill, why don't you and I get buried like other folks?"

Last summer I visited the Akron cemetery where Bob and Anne lie. Their simple stone says never a word about Alcoholics Anonymous. This made me so glad I cried. Did this wonderful couple carry personal anonymity too far when they so firmly refused to use the words "Alcoholics Anonymous," even on their own burial stone?

For one, I don't think so. I think that this great and final example of self-effacement will prove of more permanent worth to A.A. than could any spectacular public notoriety or fine mausoleum.

We don't have to go to Akron, Ohio, to see Dr. Bob's memorial. Dr. Bob's real monument is visible throughout the length and breadth of A.A. Let us look again at its true inscription . . . one word only, which we A.A.'s have written. That word is "sacrifice."

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(Last two are full-color, comic-book-style pamphlets)

PERIODICAL: THE A.A. GRAPEVINE
(Monthly)

GENERAL SERVICE OFFICE of ALCOHOLICS ANONYMOUS

A Declaration of Unity

This we owe to A.A.'s future:
To place our common welfare first;
To keep our fellowship united.
For on A.A. unity depend our lives,
And the lives of those to come.

This is A.A. General Service Conference-approved literature

I am responsible . . .

When anyone, anywhere,
reaches out for help, I want
the hand of A.A. always to be there.
And for that: I am responsible.

SOCIAL ASPECTS OF ALCOHOLISM [1]

By

Mrs. Lalita Bhatti, M.S.W., D.P.S.W.[2]

The recognition of the role of socio-psychological factors in causing and maintaining alcoholism has brought a change in the disease notion of alcoholism as a physical entity. Recently there has been an acceptance of the term 'Problem drinking' instead of 'Alcoholism'. It is argued that problem drinking places emphasis upon behaviour rather than on the person and thus avoids the more permanent label alcoholism, which tends to be attached to thepperson. This shift is mainly due to the fact that the popular approaches like-constititional, psychological and sociological, cannot help to understand and treat alcoholism independent of each other.

Two facets of Social Aspects -

The workers who strongly ahdere to the constititional approch do not give any importance to the social factors in understanding the etiology of alcoholism. Most of them, of course, agree that alcoholism could be an exogeneous stress on the family and social milien of the alcoholic. During the third decade of this century, Knight (1937) and Chassell (1938) stressed the importance of understanding the total family in order to understand individual drinking behaviour. Meeks (1976) comments, 'drinking may indicate stress or dysfunction in a social system, may be secondary to dysfunction in a social system', seems to be quite appropriate. He is of the opinion that 'some alcohol problems may reside as much as in social structures and processes as in people'.

Socio-cultural theory of Alcoholism -

Most of the epidemiological surveys have, demonstrated that the incidence of drinking have a significant association with age, sex, social status, ethnicity, degree of urbanization, quality of marital and family life. These are all sociological and demographic variables. On the other hand, in the field of psychological research no unique personality type or a unique nosological group have shown definite correlation with alcoholism (Roebuck & Kessler, 1972). Therefore, as pointed out by Cahalan etal (1969), 'Whether a person drinks at all is primarily a sociological and anthropological variable rather than a psychological one', needs a very special consideration.

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1. Paper presented at Seminar on Alcoholism organised by the Dept. of Psychiatry, St. John's Medical College & Hospital and Indian Psychiatry Society, Karnataka State Branch, on 6-6-1983.

2. Department of Community Medicine, St. John's Medical College, Bangalore - 34

Twentieth century is the age of positivism and anxiety. The technological advancements in the European and Western Society have brought a severe degree of monotomy in life. This has affected the youth very much. He finds himself as an empty shell - his family as an empty shell - his whole system as an empty shell. He is in constant search of relations and significant others. He is desperately searching meaning of life. This is an indication of acculturation of society. Whenever a society is undergoing acculturation the culturally induced tensions will reach to an untolerable level. These tensions lead to existential doubts. Roebuck & Kessler (1972) believe that 'the choice of alcohol to relieve these is determined by (1) attitudes towards alcohol and (2) the availability of substitute means of satisfaction or tension release. A similar review is expressed by Cahalan (1970) and he contended that higher rates of problem drinking in lower socio economic group might be due to fewer opportunities for recreation and tension release.

Family of alcoholics -

The behavioural scientists believe that Alcoholics' family of orientation is one of the very important factors in understanding the problem of alcoholism. In this regard several attempts have been made to explain the various socio-psychological tenets of family life. Most of the work in this field is based on the general system theory wherein the family has been considered as an open system. The expression of 'abusive drinking' as per the family system, is considered as a sign of stress within the family. Often it is seen drinking in a family starts as a substitute in the absence of usual coping mechanisms. The other view with regard to the abusive drinking in intact families is that it maintains the family as a system. Alcoholism brings stability rather than disruption in the interactional behaviour in certain families. Jackson (1954) reported the following seven stages in the adjustment of the family to alcoholism.

1. Attempts to deny the problem
2. Attempts to eleminate the problem
3. Disorganization
4. Attempts to reorganize inspite of the problem
5. Efforts to escape the problem
6. Reorganization of the family
7. Recovery and reorganization of the whole family.

Parent child relations in the families of alcoholics -

Wittman (1939) has given an account of the parent child relationship. According to her the alcoholics have oversolicitors mother and a comparatively

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stern, fobidding father; the later, the person who inspired and awe or fear and who displayed inconsistant tendencies of severity and indulgence, thus producing in the child a feeling of insecurity and helpless dependance. Shiela Daniel also found that alcoholic parents were not consistant in their actions towards children.

Parental drinking attitudes -

Jackson and Connor (1957) have shown that alcoholics came more frequently from houses in which one parent drank - usually the father. With regard to the families of alcoholism in the Indian set up according to Bhatti (1982) Channabasavanna & Bhatti (1981) and Channabasavanna and Bhatti (1983) most of the alcoholics belong to anomic families. According to them majority of the cases came from the families having unhealthy communications, poor concern and lack of leadership. The individual members have their own way of life, style of interaction and personal convictions which are often idiosyncratic. They are highly individualistic and do not bother about other family members. They hardly have any discussion and no common ways are adopted to achieve the family goals. In extreme cases, except living under common roof the family members have nothing else in common. These are called the anomic families. Anomic families contribute heavily for alcoholism and drug addiction.

In such families, the individual self is given the highest importance by the family as such. Often in such families regular leader of the family moves out quite frequently and in his/her absence some other family member accepts the leadership. Such acceptance of leadership is always to fill the gap. Therefore the leader is quite mild, non-commital, highly indecisive, rarely enters into any kind of discussion and leaves everything to others; such a leader pretends to be a broad minded leader. Also in such families due to the permanent incapacitation or the death of the actual leader, some member of the family is forced to accept the leadership. The patterns of communications are quite confusing in these families. There is always an atmosphere of imposition and overadherence. When the leader conveys the messages they are interpreted in comparison with the way the messages were being conveyed by the original leader. At times the messages are quite contradictory. The messages reflect more often the covert meaning which remains a guess work for the receiver. In such families the leader does not posses the role of a leader, still plays the role of a leader. The roles are allocated but not accepted. The patterns of reinforcement are usually temporary in nature. Such families make use of negative patterns of reinforcement. In crisis, such families turn to governmental and voluntary agencies.

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Schematic analysis of family system of alcoholics

Type of family	-Anomic type
Type of self	-Individual self
Type of leadership	-Marginal and/or stop-gap leadership
Type of communication	-Messages without any meaning and misinterpretation of the messages
Type of role	-Cognitive discrepancy and discrepancy of role
Type of reinforcement	-Through coercion and punishment
Type of social support system	-Tertiary social support system

Social class and alcoholism

In general survey results indicate that percentage of drinkers increase with increasing social status. On the other hand rates of heavy drinking, heavy escape drinking and problem drinking among drinkers are highest in lower status groups.

The middle and lower upper class might be expected to have high rate of alcoholism because of the tensions and insecurity brought about by high speed of living, industrial and commercial activity and high pressures in life. The lower classes would be expected to have high rates because of their supposed lack of controls on drinking. One problem that confronts researchers who study the association between drinking patterns and social class is the matter of social class criteria. Sociologists utilise different methoddogies and criteria in the stratification area. The four most frequently used indicators of social class are income, education, occupation and some combination of these. Cahalan etal (1969) found that heavy escape drinkers had relatively lower incomes. Ir[illegible] problem drinking related to age, sex and urbanization. Men in all age groups have a higher frequency of drinking problems than do women. Cahalan holds that role differences between men and women explain men's heavier drinking. The frequency of drinking problems in the aggregate among men was found to be highest among those in their twenties, significantly lower among those in their thirties and forties, and tapering off among those in their fifties. The degree of urbanization is related in certain ways to drinking behaviour, depending upon two variables - age and socialstatus. In conslusion, I would like to reitrate that the research in the field have established that the etiology of alcohol abuse and aocohalism is multifactorial. Equally, it is proved beyond doubt that the management outcome is always better when the family of an alcoholic has participated actively in the treatment programme-well that is the relevance of social factors in alcoholism.

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Parkinsonism Provoked by Alcoholism

P. L. Carlen, MD, FRCP(C),*†‡§
M. A. Lee, MD, FRCP(C),*‡§
M. Jacob, MD, FRCP(C),*‡ and O. Livshits, MD*‡

Seven chronic alcoholics, aged 53 to 70, demonstrated transient signs of parkinsonism provoked by alcohol withdrawal or chronic severe intoxication. All showed improvement or recovery when they abstained or decreased their alcohol intake for several days to weeks. Animal studies have demonstrated impaired striatal dopaminergic function during severe ethanol intoxication or withdrawal. Chronic alcoholism apparently can exacerbate or uncover latent central dopaminergic deficiency.

Carlen PL, Lee MA, Jacob M, Livshits O: Parkinsonism provoked by alcoholism. Ann Neurol 9:84–86, 1981

Acute alcohol intoxication has been reported to trigger akathisia, dystonia, and cogwheeling in young adults taking neuroleptics [7], suggesting that alcohol can impair central dopaminergic mechanisms in humans. During the past three years we have observed transient parkinsonism during alcohol withdrawal or chronic severe alcohol intoxication in seven chronic alcoholics. Parkinsonism provoked by alcoholism has not previously been reported.

Patient 1

A 53-year-old man with a ten-year history of alcohol abuse (24 beers and several glasses of wine daily) entered the hospital for alcohol withdrawal. He had been admitted for alcohol withdrawal two and three years previously and had had documented alcoholic liver disease for seven years. One day after admission he was noted to have marked poverty of movement, bilateral resting tremor of the feet, generalized cogwheel rigidity, and a stooped, somewhat shuffling gait with loss of associated movements. Within five days all clinical signs of parkinsonism disappeared.

A CT scan showed mild to moderate generalized cerebral atrophy. An electroencephalogram (EEG) was normal. Liver function studies showed minimal elevation of bilirubin and serum glutamic-oxaloacetic transaminase (SGOT), and the patient had mild hepatomegaly. Parkinsonian features had been noted on two previous admissions.

Patient 2

A 56-year-old man had drunk 3 to 4 quarts of gin per week for the past twenty years. A month perior to admission he had increased his intake to 1 bottle of gin daily. Two weeks before admission he was noted to have a slow gait and tremor at rest. His wife, a nurse, related that during two prior drinking episodes the patient had shown similar signs of parkinsonism, which resolved with abstinence.

Examination showed an emotionally depressed man with slowed speech, resting tremor, and cogwheeling rigidity of the right arm. He had a postural tremor in both arms. His gait was wide based and he was generally bradykinetic. He had palmomental and snout reflexes. Three days later, it was noted that he had no parkinsonian tremor and his cogwheel rigidity had decreased. Nine days after admission, no rigidity was noted and his bradykinetic gait had greatly improved. Investigations in the hospital showed no biochemical evidence of liver disease. An EEG showed minimal abnormalities.

Patient 3

A 62-year-old woman who had been drinking up to 24 beers daily for twenty years had a one-year history of resting tremor in the arms which was reportedly increased during alcohol withdrawal. She was noted to have a shuffling gait, cogwheel rigidity and resting tremor in the arms, an expressionless and flat facies, emotional lability, and decreased insight into her condition. She was diffusely bradykinetic.

Four days after this visit, having maintained abstinence, she was admitted to the hospital with an unsteady, shuffling gait. Her parkinsonian signs had decreased. She had no evidence of liver disease. CT scan showed moderate ventricular and sulcal atrophy, and bilateral basal ganglia calcification. She was reassessed six weeks later and ostensibly had not used alcohol. Signs of parkinsonism were still present but were further diminished.

Patient 4

A 64-year-old man had drunk heavily for thirty years, including a quart of whiskey per day and 24 beers per week for the previous four months. Admission was prompted by a seizure. During the first 48 hours in the hospital the patient experienced withdrawal symptoms, including a postural tremor that was controlled with chlordiazepoxide. On the third day after admission he was noted to have a bilateral pill-rolling tremor of the upper extremities with a frequency of 3 to 5 per second. He had masked facies, positive glabellar tap, cogwheel rigidity of the arms, and

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bradykinesia. His posture was stooped, and he had a shuffling gait with loss of arm swing. Gradually over the next week, all clinical signs of parkinsonism resolved. A CT scan demonstrated mild to moderate generalized cerebral atrophy. The EEG showed mild, generalized slowing, and liver enzymes were modestly elevated.

Six and twelve months previously, during brief periods of alcohol withdrawal, he had noted a marked tremor which was quite different from the pill-rolling tremor of the present admission. However, he had also noted a slowness and stiffness of movement during the first days of each withdrawal episode.

Patient 5

A 66-year-old woman who had averaged 6 to 8 beers per day since the age of 30 had a long history of tremor (probably of the postural or benign essential type) which was decreased with alcohol intake and increased during withdrawal. For two years prior to admission she had complained of a pill-rolling tremor, particularly in the right hand, which increased and gradually spread to both arms. Six months before admission the patient noticed increased abnormal involuntary movements of the tongue and lips. There was no history of tranquilizer use.

On admission, two days after her last drink, the patient was noted to have masked facies and a slowed, stiff gait without associated arm swinging. Her gait was also ataxic. The glabellar tap response was positive. She had a coarse flexion-extension tremor of her fingers, greatest on the right side, which decreased during voluntary movements. Cogwheel rigidity was present in both arms. She had constant lip smacking and repeated protrusions of her tongue. Generalized hyperreflexia was present, but her plantar reflexes were flexor. She was disoriented to place and date and had impaired recent memory. There was no biochemical evidence of liver disease. CT scan showed marked cortical and generalized cerebral atrophy. Two weeks after admission the patient was started on Sinemet because of the signs of parkinsonism. She improved after one week. Sinemet was discontinued, and four weeks later she had a normal gait, no rigidity, and almost no lingual-oral dyskinesia.

Patient 6

A 70-year-old man had abused alcohol since the age of 18, particularly in the past ten years. Two years previously he had been diagnosed as having alcoholic liver disease on the basis of abnormal liver function studies, mild hepatomegaly, and an abnormal liver scan. He was admitted with severe alcohol withdrawal symptoms. His posture was stooped, and he walked in short, shuffling, unsteady steps with loss of arm swing. Over three weeks in the hospital his gait improved but did not return to normal. A second admission four months later was for severe alcohol withdrawal symptoms. Nine days after admission, neurological consultation showed impaired fine motor movements, bradykinesia, rigidity, stooped posture, and a shuffling gait with loss of arm swing. A CT scan demonstrated moderate cerebral atrophy. EEG showed mild generalized slowing. Over the next two weeks his gait again improved but was not completely normal. The patient had first noted a shuffling gait two years previously and had been aware of a deterioration of gait during previous episodes of alcohol withdrawal.

Patient 7

For several months a 70-year-old woman had complained of a progressive shuffling, slowed gait and impaired memory. Her husband had noted increased bradykinesia after several drinks, which decreased by the next morning. She had averaged at least 8 oz of vodka daily for many years. Examination revealed impairment in orientation, recent memory, calculation, and general knowledge. She had a slowed gait with loss of associated swinging of the left arm, resting tremor of the left arm, and decreased facial expression. She also demonstrated bilateral postural tremor and mild intention tremor of the left arm, impaired tandem gait, and mild proximal muscle weakness. Liver function tests were normal. CT scan showed moderate diffuse cerebral atrophy.

Reexamination three months later, after she had reduced her alcohol intake, demonstrated no resting tremor, a fluid gait with associated arm swinging, and more expression to her face. The signs of dementia and cerebellar dysfunction had also diminished.

Discussion

Although alcoholism-induced Parkinson disease has not to our knowledge been reported previously, this usually transient syndrome must not be rare. Our patients were all in the appropriate age range to develop idiopathic Parkinson disease. None were receiving neuroleptic drugs. Patients 1, 2, and 4 had a history of two prior parkinsonian episodes before admission. Patients 2 and 5 had a history of parkinsonian tremor, and Patient 6 had shown a mild shuffling gait one to two years prior to admission (Table). Patients 1, 3, 4, and 6 developed their parkinsonism during the first few days of alcohol withdrawal, Patients 2, 5, and 7 only during heavy drinking; Patient 3 had both modes of presentation. Patient 5 also developed a lingual-oral dyskinesia while drinking. Three patients demonstrated a withdrawal syndrome along with their parkinsonism.

This syndrome differs from the chronic progressive acquired hepatocerebral degeneration syndrome described in chronic alcoholics with severe liver disease and portal-systemic shunting [9]. Most of those patients have extrapyramidal neurological signs other than parkinsonism. Although three of our patients had mildly elevated liver enzymes and two had moderate hepatomegaly, none had other signs of liver disease and none had a history of hepatic encephalopathy, which was present in 80% of the series of Victor et al [9].

The effects of ethanol on dopamine metabolism in the basal ganglia may help to explain the syndrome

Patient No., Age (yr), and Sex	Parkinsonism Provoked during: Alcohol Withdrawal	Parkinsonism Provoked during: Chronic Intoxication	Liver Abnormalities	CT Scan	Recovery	Other Comments
1. 53, M	+	–	Mild	Atrophy	Full, 5 days	Two prior episodes
2. 56, M	–	+	None	Not done	Almost complete, 2 wk	Two prior episodes
3. 62, F	+	+	None	Atrophy and basal ganglia calcification	Partial, 6 wk	Pill-rolling tremor for 1 yr
4. 64, M	+	–	Mild	Atrophy	Full, 1 wk	Two prior episodes
5. 66, F	–	+	None	Atrophy	Parkinsonism: full, 6 wk; dyskinesia: partial, 6 wk	Pill-rolling tremor for 2 yr, lingual-oral dyskinesia for 6 mo
6. 70, M	+	–	Mild	Atrophy	Partial, 7 wk	Two-year history of mild shuffling gait
7. 70, F	–	+	None	Atrophy	Almost complete	

we observed. A subhypnotic dose of ethanol reduces dopamine turnover in the substantia nigra and caudate nucleus in rats [1]. Increased striatal dopamine release is seen in acutely intoxicated rats with blood alcohol levels under 300 mg/dl; decreased striatal release occurs with higher blood alcohol levels [4]. Striatal dopamine release is also reduced during the first few days of ethanol withdrawal [4]. In mice, ethanol withdrawal is associated with diminished responsiveness of striatal dopamine-sensitive adenylate cyclase activity [8].

These biochemical changes, if present in humans, could help to explain why four of our seven patients seemed to develop or greatly augment their signs of parkinsonism during alcohol withdrawal. The reason why other patients developed parkinsonism during prolonged drinking episodes could be related to higher blood ethanol levels, periods of relative withdrawal, or other factors. We propose that our patients had underlying parkinsonian pathology, the effects of which were intensified by chronic alcohol intoxication and withdrawal. All the patients improved with maintained abstinence. The six who had CT scans showed cerebral atrophy, an expected finding in chronic alcholics [2, 3, 5, 6]. Patient 3 also had bilateral basal ganglia calcification. These findings indicate that one should wait a few weeks before starting antiparkinsonian medication in recently abstinent alcoholics with newly diagnosed mild parkinsonism. Alcohol abuse would be expected to be detrimental to parkinsonian patients.

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CHIEF MINISTER'S TROPHY

21st	Day	Saturday	18th	February	1989
22nd	Day	Saturday	25th	February	1989
23rd	Day	Friday	10th	March	1989
24th	Day	Saturday	11th	March	1989
25th	Day	Friday	17th	March	1989
26th	Day	Sunday	19th	March	1989

GOVERNOR'S TROPHY

27th	Day	Fridey	24th	March	1989
18th	Day	Saturday	25th	March	1989

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CREST is actively involved in Preventive Counselling in the field of Drug Addiction.

Preventive Counselling is giving correct and adequate knowledge of how Drugs act and their harmful effects, developing positive attitudes needed for a healthy personality which needs no props eg. Drugs or Alcohol, and encouraging people especially youth to seek help and advice whenever emotionally upset or depressed.

We have conducted many Seminars on the subject "Yes to Life, No to Drugs".

A survey involving 3000 youth in Karnataka was undertaken and questions on all aspects of life were asked. In the section of Drugs, we found that *60% youth took Drugs regularly*, and *8% had tried* it at least once.

Crest participated in a programme 'Yes to Life, No to Drugs' over A.I R. which was broadcast every Thursday and carried on for several weeks. This programme included parents, students, educators, journalists and rehabilitated persons.

We have programmes in colleges which include a questionaire on Drug Addiction followed by a time of discussions, and we screen a very effective video film "Mannas" which shows a young student from a good family background succumbing to this problem due to peer pressure.

We have programmes for Youth groups for various clubs, Associations etc , where we deal with this major problem of Drug Addiction.

Drug Addiction is very closely related to Smoking and Alcoholism. Since the latter two are socially acceptable and addictive, the problem is immense.

SMOKING—NICOTINE— The Man—Made Monster

Cigarettes contain tobacco which has an alkaloid called *nicotine*. It is a poison and is used widely as an ingredient in insecticides. In cigarettes, it is found to act as a stimulant. Habitual and frequent smoking is harmful to the body.

Besides the poision Nicotine there is Carbon Monoxide present in a concentration 400 times the amount considered safe, and hydrogen cyanide 160 times. *Cigarette smoke also contains a radio active compound* plutonium 210. (One drop or 70 mgs of nicotine will cause the death of a man in a few minutes).

ALCOHOLISM :

By pharmacological definition, alcohol is a drug and may be classified as a sedative, tranquilizer, hypnotic or anaesthetic. It is the only drug whose-self-induced intoxication is socially acceptable.

Persons with alcoholism are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance, or an interference with their bodily and mental health, their-inter-personal relations, and their smooth social functioning, or who show the early signs of such development.

Alcohol is an important and etiologic factor in suicide, automobile accidents, and injuries and deaths due to violence. The health problems for which alcohol is responsible are only part of the total social damage which includes family disorganization, crime and loss of productivity.

Drugs of abuse and their effects :

Substances with abuse potential range from simple kitchen spices to highly sophisticated drugs. All these substances may be divided into 5 categories.

1. Narcotics 2. Sedatives 3. Tranquilizers 4 Stimulants and 5. Hallucinogens.

Medically defined narcotics are drugs which produce insensibility or stupor due to their depressing effect on the central nervous system.

Included in this definition are opium, opium derivates (morphine. codeine, heroin) and synthetic opiates (methadone and meperidine). All other drugs susceptible to abuse are non-narcotics.

Many of these drugs have important legitimate applications. Narcotic, Sedatives, tranquilizing and stimulating drugs are essential to the practice of modern medicine and research.

To the abuser, these drugs produce a change in his emotional responses or reactions. The abuser may feel intoxicated, relaxed, happy or detached from a world that is painful. hostile or unacceptable to him.

With repeated use, many drugs cause physical dependence. This is an adaptation where by the body learns to live with the drug, tolerates ever-increasing doses and reacts with certain withdrawal symptoms when deprived of it.

Withdrawal symptoms disappear as the body once again adjusts to being without the drug or if the drug is re-introduced. Tolerance represents the body's ability to adapt to the presence of a foreign substance. Tolerance does not develop for all drugs or all individuals, but with drugs such as morphine, addicts have been known to build up **great tolerance very quickly.** The abuser is enslaved by his habit of psychic or psychological dependence present in most cases of drug abuse. *The abuser feels he cannot function normally without the drug. It helps him to escape from reality from his problems and frustrations. The drug seems to provide the answer to everything including disenchantment and boredom.*

WHY DO PEOPLE TAKE DRUGS—LET'S TALK ABOUT IT

The following reasons are generally given by addicts

a. Experimentation or curiosity or adventure
b. Peer pressure—Friends pressing to try
c. Search for an identity.
d. Escape from reality and demanding situations
e. Rebellion-protest against social values
f. Family disharmony
g. Boredom, depression
h. Dependency after medical use
i. Media Influence
j. Rock culture, films, hero-worship

Addiction :

Has been defined as a state of periodic or chronic intoxication produced by the repeated consumption of a drug and involves tolerance, psychological dependence, physical dependence and an overwhelming compulsion to continue using the drug with detrimental effects.

Habituation :

Is the condition resulting from repeated consumption, with some psychological dependence, but no physical dependence or compulsion.

Drug dependence :

Is a more general, term and is described as a state arising from repeated administration of a drug on a continuous basis (e.g. Drug dependence of the morphine or barbiturate type).

Depressants or Sedatives

Include a variety of old and new drugs. The most common are the barbiturates.

Tranquilizers

Can be used to counteract tension and anxiety without producing sleep or significantly impairing mental and physical function. Major tranquilizers are those with anti-psychotic activity.

Minor tranquilizers are used in the treatment of emotional disorders characterized by anxiety and tension. Many are used as muscle relaxants.

Stimulants

These drugs directly stimulate the central nervous system, Examples are caffeine (coffee, tea, cola etc.) Amphetamine is also potent. Cocaine is a dangerous stimulant.

Hallucinogens

Distortions of perception, dream images and hallucinations are characteristic effects of a group of drugs called hallucinogens, psychotomimetics, dysteptics or psychedelics. They include mescaline and *LSD*. (Lysergicacid Diethylamide)

They have no general clinical medical use but are being used as drugs of abuse.

Marihuana (Cannabis) :

There is no medical use for marihuana.

Leisure Hours and Drugs

88 percent of student addicts in Madras study in colleges which have attached hostels.This obviously means that greater care should be taken by hostel wardens and college authorities to ensure that the spare time of students is gainfully employed.

Drug addiction is more frequent among those students who have idle time aud spare money. The survey reveals that 54 per

cent of the addicts get more than 15 hours of leisure time per week and that 30 per cent even have 40 hours of leisure time per week.

The survey estimates that on an average, students get between 600 to 1000 hours free time very year, not counting the two months of vacation. The survey suggests that parents. academic authorities and the government should take note of this and try to see that this time is more usefully spent, perhaps by way of social work or compulsory sports.

Withdrawals: When the drug-abuser stops taking drugs, he goes through a period of severe physical withdrawal symptoms.

1. Hallucinations : Hearing sounds and voices and seeing horrible and nightmarish visions which are not there. This is due to malfunctioning of his central nervous system.
2. Vomiting 3. Temperature fluctuation
4. Continous sweating
5. Goose-pimples. i.e. cold shivers and jitters,
6. Body pain and severe pain in the joints.
7. Constipation 8. Sleeplessness
9. Loss of memory 10. Loss of reasoning powers.

Treatment

Tha treatment consists in hospitalisation and sealing of all the parts of entry of the drug. This operation is a formidable task. The drug dependent is cunning. and knows how to deceive. Invariably he manages to obtain his drug surreptiously and thus defeats the purpose of treatment. Evidence of the withdrawal syndrome is an indication that the patient is not obtaining tbe drug. Unfortunately some drugs do not produce a withdrawal syndrome. However close observation of the drug dependent during the withdrawal phase shows him to be restless, sleepless and suffering from loss of appetite. These symptoms are enough to prove that he is off his drug.

The withdrawal symptoms are covered up, by the administration of a blanket of tranquilisers and hypnotics. The general nutrition of the patient requires attention. Vitamins galore must be the order of the day, as these patients are generally severely depleted of vitamins and nutrients, as they usually restrict their food intake while taking a drug which satisfies them completely.

Role of the family

The real treatment starts after the withdrawal phase, when psychotherapy individually or in a group aid in rebuilding the personality of the drug dependent. The family members should be taken into confidence, for without their aid nothing may be achieved. The family members contribute in no small measure to creating and perpetuating the drug dependence

Inspite of every effort on part of the therapist a bulk of therapy comes to no avail as mentioned already. *Nevertheless an air of optimism should prevail, and efforts to rehabilitate the drug dependent should continue.* The drug addicts need constant attention, affection & reassurance. Drug–Abusers are physically and psychologically dependent on drugs They are sick people. They need intensive treatment and rehabilitation. When the drug–abuser hits rock–bottom, i.e , when he has nowhere to go, when he is on his own resources which are nil and no one is going to help him anymore and when he realises that he has reached a point of no return and utterly helpless-that is the time when he is ready for therapy and rehabilitation. Let us all unite to stop Drug addiction which is threatening our youth's progress, their Health & their Happiness.

Let us all say " No to Drugs "

CREST

Centre for Research, Education, Service and Training for Family Life Promotion dedicates this section to the greatest treasure of India – her YOUTH !

May we the educators and parents be true to our task of giving them a wholesome healthy and spiritually strong formation.

"CREATING RESPECT FOR LIFE"

Report of III National Conference

"Yes To Life"

Presented by Asian Secretariat

"RESPECT FOR LIFE"

C/o CREST, 14 High Street
Bangalore–560 005

Organizing President : **Prof. Ninan Thomas**
Mar Ivanios College

Programme Director : **Dr. Marie Mignon Mascarenhas**
Asian Secretariat

Mother Teresa (seen with me) once invited my husband & me to join her in addressing a gathering after which she said "Let us go around and meet with people - you speak to the head & I will speak to the heart" M. M. Mascarenhas

THIRD National Conference on "Creating Respect for Life"

"Everytime a child is born it shows
that God still has faith in Man"

—Tagore

The III National Conference on 'Creating Respect for Life' was held in Trivandrum from January 12-15th 1989. Topics & Workshops & Films & Slides focussed on various topics like "The Meaning of Life"—"Population Explosion — A Hoax?', Human Sexuality & Sex Education, Masculinity & Femininity, Abortion, Suicide & Euthanasia Also, the Dangers of Sex Determination, Female Foeticide & Infanticide & Abortion Education, its complications & Counselling, women in India & their problems etc etc,.

100-delegates from 11 states actively. participatied in this Conference. The Conference was directed by Dr. Marie Mignon Mascarenhas of the International Federation for the Right to Life & expert speakers included Dr. John Iype, Mrs. Phyllis Farias, Frs. Abello, Kackanath & Daniel & Mrs. Mary Zaccariah & Lillian D'Mcrais.

Elections for the new National Association were held & Mr. Hugh De Nazareth of Bangalore was elected President. The Secretariat address is "National Association, Respect for Life", c/o Good Shepherd Provincialate, Museum Road, Bangalore–560 025

The Organising President Prof. Ninan Thomas of Mar Ivanios College was assisted by a team of staff & students.

His Excellency Archbishop Mar Gregorius addressed the delegates & gave his full encouragement to improving the quality of life in its fullest form & as God meant it to be. All the lay people appreciated his wonderful support and help.

Four Resolutions as follows were discussed & adopted unanimously :—

1. That Human Life from its conception to natural death will be fully respected without discrimination of age, sex, colour or race.

2. Seminars be held for Parents, Teachers & Students on Family Life Education & Human Sexuality are an urgent necessity.

3. Resolved, that because we are aware of the need for Responsible Parenthood, we strongly oppose the violation of the most basic right, the 'Right to Life' by the practice of abortion. Further resolved that we shall encourage natural means of exercising responsible parenthood.

4. This National Conference on Respect for Lite strongly condemns the practice of giving & accepting dowry as a social evil which disrespects women.

Anita's Journey into Life a Colouring Educational Book for children (9-12) was released, as also the Malayalam Booklet on 'Respect for Life' to commemorate **1989, the International Year of the Female Child.**

Literature & details of membership can be obtained from the National Secretariat. Please help us to help "LIFE" by becoming a member. Dont wait !

Mother Teresa's Message to the Conference

"I thank you for your kind invitation to attend the III National Conference on "Creating Respect for Life" in Trivandrum from 12th to 15th January. I am sorry to disappoint you, but it will not be possible for me to attend this conference as I have some prior engagements. I know you will understand and I wish the Conference every success and blessing. You know how important *"Respect for life"* is to me. No one has the right to destroy or kill or murder—neither the unborn

child by abortion—nor the old, the mentally retarded or cancer patients—for each one of them have been created by the same loving hand of God for greater things—to love and to be loved—a child of God—my brother, my sister.

This brings you my prayers and wishes, and those of our sisters and the poor for a very happy Christmas. May the Christ Child fill you with His peace. love and joy and may the New Year 1989 be full of God's grace and blessing".

Conference Programme

January 12th :

Inaugural & Keynote Address

PANEL I "THE MEANING OF LIFE" from Scientific, Philosophical & Theological Aspects.

FILMS WORKSHOP on 'HOW TO CREATE RESPECT FOR LIFE'

Opening of Exhibition on 'LIFE' by Princess GOWRI LAXMI BAI

Evening—Vedio Films will be screened DAILY

January 13th :

PANEL II :POPULATION EXPLOSION—HOAX OR REALITY? from Demographic, Social & Health Aspects

FILMS, WORKSHOP on ' POPULATION ISSUES"

PANEL III "DESTROYING LIFE" from Foeticide—Abortion infanticide, Suicide & Euthanasia.

WORKSHOP on "ABORTION" NETWORKING

January 14th :

PANEL IV "HUMAN SEXUALITY" from the Physical. Psychological, & Celibate Aspects.

Creating Respect for the Handicapped—2 Reports South & North East

FILMS PANEL V "MASCULINITY & FEMININITY"
WORKSHOP on "SEX EDUCATION"

"The Springtime of Your Life" Slide Show.
Elections – National,

January 15th :

PANEL V "WOMEN IN INDIA", from social, Religious & Cultural Aspects.

"LIFE A GIFT TO RESPECT" Passing of Resolutions & Valedictory Function – Conclusion.

"In our Lives only God is UNCHANGING LOVE AND ETERNAL LIFE"—Usha Gaba, Asha & Ramesh Parmanand—FRIENDS of CREST.

* * *

CREST is a voluntary trust dedicated to Family Life promotion through Research in Youth Problems Education to all concerned, Counselling and Training. Also has excellent Publications.

For Programmes & Publications.write to :
Director, Crest, 14 High Street. Bangalore–560 005.

EXCERPTS of Papers are printed

(Full text available from Secretariat)

Inaugural :

The Conference began with an Invocation sung by Miss Annamary Thomas. Prof. Ninan Thomas the Organising President then welcomed the gathering.

The Conference was then inaugurated by the lighting of a lamp by Father Thomas Kotharathim, Principal of Mar Ivanios College, who addressed the gathering. The Precious Feet symbol was then pinned on to the Guests & Prof. Ninan Thomas.

The **Keynote Address** was delivered by the Programme Director, Dr. Marie M. Mascarenhas, Board member of the International Federation for the Right to Life.

Creating Respect for Life :– *Keynote Address*

In 1989, the century of anxiety and tension, in India and the world at large the word "respect" like "discipline" seems to be outdated. We live in an age of great technological triumphs, and yet even a country like America admits to malnutrition and increasing deaths due to the diseases of "civilization" which now includes AIDS.

Man has landed on the moon and yet the hearts of men and women seem to get harder and more apart for no solution seems in sight to rising adolescent pregnancy, divorce, loneliness, mental illness and abortion. Modern culture reflects many tensions and contradictions. Too often today the vision of reality is fragmented. At times experience is mediated by forces over which people have no control. Sometimes there is not even an awareness of these forces. *The temptation grows to relativize moral principles and to priviledge process over truth. This has grave consequences for the moral life as well as for the intellectual life of individuals and of society.*

Modern culture is marked by pluralism of attitudes, points of view and insights. The situation rightly requires mutual understanding. It means that society must respect those who have a different outlook from their own. But pluralism does not exist for its own sake. It is directed to the fullness of truth. **The respect for persons which pluralisation rightly envisions does not justify the view that the ultimate question about human life and destiny have no final answers or that all beliefs are of equal value, provided that none is asserted as absolutely true and normative. Truth is not served in this way.** It is not true to say or believe that there is no absolute right or wrong and that we must accept the shades of grey in between. The ideal may be difficult to reach, but the Truth can never be in between.

To Love is to move from "death into Life", to Live is to grow into the stature of the truth, and we must aspire to grow into that stature.

Prior to 1930, all Christian denominations condemned artificial contraception. The Church of England at its Lambeth Conference in 1930 suggested that the use of artificial contraception by married couples might be morally licit in some difficult situations. Over the next three decades, many Churches dropped their moral condemnation & some even suggested that artificial contraception may be a positive good. By the end of the 1960s, Western society came to believe that the artificial methods of birth control constituted an outstanding contribution to modern medicine.

With this evolution of social & religious attitudes, often referred to as the Contraceptive Mentality, new expressions entered the public debate, such as "children should be planned", "every child a wanted child" & a woman's right to control her own body". The child was now perceived in a new light — a non-person, an intruder, an inconvenience, a human product, even as an evil !

The acceptance of abortion is the outcome of this change in attitude so that now both contraception & abortion are widely held as cultural norms.

"We Indians are in danger of losing our respect for human life. It is happening step by step. Our attitude to human life is becoming coarsened and desensitized."

A new attitudinal & behavioural change is occurring so that a new sexually permissive society is being moulded. Indeed, sexuality is being promoted as a recreational pastime a manifestation of the pleasure instinct, an irresistable biological drive, a passing love affair without deeper meaning or commitment. At times it is projected as an experiment in mutual sharing & caring, what is described as "relational sex". But it has no roots so that it merely leads to a form of serial polygamy.

Some of the results of these are seen in increasing :

Divorce : The attitude to male–female relationships does not foster the deeper meaning & nuances of married love which underpin the concept of an indissoluble and faithful union. The liberalization of divorce laws was inevitable in this social climate.

Infertility: The sexually transmitted diseases & the contraceptive practices including abortion are having a devastating effect on female fertility, a medical problem that opened up the field of modern reproductive technology. So devastating is this complication that society now turns a campassionate ear to the pleas for in vitro fertilization, without coming to grips with the ethical, social, legal & economic consequences of such procedures. We are now being invaded by the "new religion" of –

Secular Humanism : which is —

1. the promotion of abortion;
2. aggressive birth control programmes;

3. recreational sex;
4. the availability of pornographic material;
5. the legalization of cannabis use;
6. the legalization of euthanasia;
7. the liberalization of divorce;
8. the legalization of homosexual acts.

Science can be used to enhance human freedom but separated from ethics, man becomes continually exposed to grave risks. Love for the human person comes from a vision of man's truth, dignity and incomparable preciousness. This truth and dignity are eternal and hence human life is to be perceived as a value in itself, a value which is not dependent on the usefulness or comfort or success that accompanies it. That life from the moment of conception or fertilisation till natural death is sacred is an old Indian belief. But how gravely has it been obscured by genetic engineering now under the guise of 'gene-therapy'? And the exploitation that goes on under the name of research? And that this exploitation takes place in the poorer people through medical experimentation by doctors, is to me the gravest form of **social injustice.**

Medical Research must and should go on, but it must always be guided by respect for the individual, his/her good, and their basic right of life. It must never be commercialized or taken undue advantage of.

Problem areas like the correct interpretation of 'quality of life', 'selective breeding', 'female foeticide', amniocentesis and chorionic villus biopsy', breeding out undesirable characteristics, tissue transplants, 'donor gametes'. In vitro fertilisation (IVF) embryo transfer, hormonal implants, surrogacy, eugenics and euthanasia must be confronted and a Christian and Humane Ethics arrived at.

Alternative technology can be developed for e.g. Tubal Ovum Transfer as an alternative to the highly expensive, largely unsuccessful, and emotionally traumatising, process, of IVF.

This **sacredness of human life** *is present not only in sacred texts of various religions, but also in the religious psyche of the vast majority of the followers of different religions. This was evident in a survey conducted by Dr. Karkal when an overwhelming proportion of Hindus—90.34%, Muslims—94.61%, Christians–94.07%, Sikhs–96.07%, Parsis–87.31% and Jains–92.79% opted for standard or even extraordinary medical care in the case of terminally ill patients.*

This is in India the country which gave light to the two greatest persons of the century—Mahatma Gandhi and Mother Teresa. And so we must ask ourselves what does the National Association of Respect for Life aim to do in this Conference and after it through its Secretariat and its branches or local and regional chapters? it aims to promote that truth that belief in our culture which has been hidden and obscured and lies dormant and needs to be awakened for Man's good and our country's good, for what is good for individual man can never be bad for his family and for the country. **In the ultimate analysis it is the people who make their nation and this with God's help and yours is our stated objectives.**

Let's Help each other to Live In Love!

The First Talk of the Conference was on the Philosophical Point of View

—by Fr. Lawrence Abello of Calcutta

I want to develop a concept of Respect For Life–that does not demand religious belief. In other words we should be able to explain the foundation of respect for life of a human being, a foundation, that will be understandable by a secular humanist.

The first consideration regards truth. A truth such as a square is not a circle is obvious to all–no reasonable person can disagree with that. This is a truth known by metaphysical evidence. The next level of truth is known by physical evidence, such as the shape of the earth. Here we already have disagreement. For instance in Calcutta one often sees the inscription on the walls "the sun revolves around the earth once a year". The people who write that belong to the "flat earth society" whose members believe the earth is flat. Here we must make a distinction–there is every evidence, though we can never judge another's conscience, that these people are very sincere and find much fulfillment when they write this at 2.00 a.m. while I am sleeping. It is not a question judging another's sincerity or holiness but of judging the truth of their beliefs, where truth is understood as conformity of one's concept's to reality.

Keeping in mind the nature of truth we now address the issue of Respect for Life. This I shall do very concretely by the study of 3 cases. (2 are given in this excerpt)

Case 1 :

Ram was hit by a taxi and left handicapped for life. He is working in a store owned by a rich entrepreneur who has

shaved the scale weight to be 800 gms. instead of 1 kg. as marked. The clients are the very poorest people whose children are suffering brain damage due to malnutrition. The owner has told Ram to use this false weight or lose his job So Ram must steal from the poorest people or see himself, his wife and 5 children, starve to death. Suppose, as is sometimes the case that the only alternatives are to steal or starve what should Ram do ? Most audiences will be divided–some say steal, some starve–My aim is that it is unfair on my part to ask them for an answer which is guess work and is not the result of a studied solution. If I were to ask somebody–How do I go there ? The person cannot answer if I do not know where I want to go or if I am not going anywhere. So it is with Life–if we have not examined whether there is a goal or a destination of one's life (or even if there is a purpose at all) then how can I know whether stealing or starving is the way to reach that destination.

In the dilemma of stealing or starving many people would say the purposes of life is to survive. Now we have postulated life's purpose and it is obvious that the right way to reach that purpose is to steal. However, anyone who would resolve major questions. such as stealing or starving on the basis of survival, which includes money, reputation etc., is totally ignoring any reference to a destiny beyond this life. If such a person is consistent, which often people are not, that person should be a materialist or secular humanist who believes that each individual goes to dust (zero) Then I would ask Ram whether his life has meaning. His answer that when he dies he will be happy to have passed on his life to his children and he is ready to go to dust.

My further question is : Ram have you helped your children by prolonging their lives if human beings merely go to dust ?" His aim is that they will pass on lives to his grand children. However, scientifically and philosophically not to speak of faith we know his lineage will come to an end with a finite number of dependants– all of whom go to zero. Ram has not given me an answer about the meaning of life if we are going to zero. The only meaning human beings would have is to serve

a super power, to develop the universe much as animals and computers seen human beings.

Case 2 :

Shanthi a 25 year old teacher is from a good family in Calcutta. She spends her free time and extra salary to educate and feed the poorer children, who are brain damaged because of malnutrition both before and after birth. I asked her why she does that ? Her answer is that she does not believe in God and does not believe there is a destiny beyond for human beings. She adds that she does it to help the children to develop both physically and intellectually inspite of these mental handicaps. She feels good about doing it and that is justification enough. My further Question, are you really helping the children if those children are going to zero ? Why not give them a painless poison like Warfarin which causes digestion of ones own blood due to internal haemorrhage and bring about a most painless death ? Why prolong their lives of alloyed joys and sufferings but mostly sufferinga, if they are going to zero anyway ? She interjects "How could I kill the children". My answer is that your beliefs do not square with your behaviour. You believe people go to nothing and yet you Respect Life. But you have not answered my questions to show me how you are helping the children. Shanthi you remind me of a flat earther who flies around the world both from East to West and North to South and returns from his journeys saying the earth is flat. He has not explained how he can squrare his beliefs with his behaviour.

There are millions of children put to death by their parents through abortion. The most basic reason for this is two fold ; either ignorance about the fact that the child before birth is fully a human being with an eternal destiny or the error that a suffering child is better off dead. People think a suffering child is better off dead because, once again they reduce a human being to an animal level. In other words the most basic cause for the human life in general and abortion in particular is a spiritual bankruptcy in society. To study the more 'proximate causes of abortion we turn to history. In the 5th

century B.C. the Greeks had widespread contraception which led to a very high abortion rate–so high that the birth rate went negative. Keep in mind that their birth rate had to be very high–something like 8 children per couple–due to high mortality brought about especially by epidemics the Hippocratic oath against abortion was drawn up in 450 B.C. The Greek population diminished to the extent that the Romans overran the empire. The Romans went through exactly the same syndrome. In 130 A D. Soranos of Ephesus, living in Rome, wrote a work–describing 13 ways the Romans were practising contraception.

Clearly there is a connection between contraception and abortion and this connection is confirmed once again by the Syndrome in modern societies. *Every country in today's world that has contraception invariably has also turned to abortion.*

Now what is the philosophic connection–Let us take an example. Suppose you have somebody that is very overweight, there is nothing wrong in controlling his weight. Likewise there is nothing wrong in controlling the number of children, especially in Today's World in which the Life expectancy has increased dramatically due principally to the control of epidemics. However the fat man should diet to control his weight i.e. avoid high calorie foods and choose the low or non–calorie foods. Instead of dieting, there are people who have their healthy intestine mutilated so that it cannot assimilate most of the calories. Others control their weight by taking pills to destroy the excess calories in the system. After a sumptuous meal the Romans made themselves vomit in order to eat more. The consequence of these unnatural ways to control one's weight, involves a deliberate destruction of God's Gifts of our bodies and minds. The sexual Act is designed by God for 2 reasons.

a) To ensure race preservation

b) for conjugality i.e. to express the total self gift of love that husband and wife have made to each other in marriage. If one destroys deliberately the race-preservation meaning (procreative meaning) by contraception and also destroys the conjugality meaning because contraception is an act done to self–then sex becomes only pleasure. Hence the need to reflect on Life, its true purpose & ultimate destiny.

India's Population Problem
A Myth or Reality ?

—Dr. M. M. Mascarenhas

India, the subcontinent with surplus food for 3 years—Increased Primary School Education by 300%—with the Richest Human resourses and land and sea wealth, has more than enough to "develop" its people. **Mahatma Gandhi said "There is enough for everyman's need but not for everyman's greed".**

True and authentic development has been prevented by the Population Control programmes thrust on India by the *West* by Funding agencies and International Organisations who have misled our people.

We do not want "development" if it means "Divorce, Drugs, Depression and Disillusion which is what the West is exporting to us." India has been giving her best brains to the West for their benefit in Medicine, Space Technology and Education. How has the West repaid us ?

We want to grow into our own cultural heritage imbibing the best from the world and yet not being swept off our feet into believing that we are poor, underdeveloped and to be pitied.

Read how in Gandhiji's country of "non violence"—female foeticide, Infanticide and crimes against women are increasing. Shatter your belief that India has a population problem. Read the full text of the paper by Dr. M.M. Mascarenhas author of *Population Education for Quality of Life* (2nd Edition by Oxford Publishing Co) and also "Feminism Hijacked down the Slippery Slope" by Ms. Mary Paul and Dr. M.M. Mascarenhas.

Available from the National Secretariat

* * *

"God always forgives. Man sometimes forgives, Nature never forgives."

'Destroying Life'

This was an important panel–as it came to the crux of the Conference. **Dr. JOHN IYPE**–spoke on **'ABORTION'**

He discussed various cases of abortion and then tackled the very important question. When dies life begin ? This is answered by people in various ways. The ultra modern Theologians say after 14 days, others 3 months but from science we do know that life begins from the time of conception or fertilisation. Dr. Iype then discussed the different methods of Abortion and also spoke of the effect of Abortion on the mother. Through the talk he gave us much food for thought, To mention a few of his thoughts–A 'union' of the unborn, 'Once there is no respect for the unborn then there is no respect for anyone'–'It is easy to scrape the baby from the womb but it is not esay to scrape the baby from the mind of the mother.'

He concluded by saying–'It is not sufficient to make lip sympathy. Let us Act.'

This was followed by a talk on **"Suicide"** by **Dr. Mercy Abraham of the Dept. of Psychology University of Trivandrum.** She began by saying that the theme of the conference is unique. It embodies all of our values and beliefs

What is Suicide ? Taking away ones life prematurely at a most inappropriate time. She emphatically said, one does not have the right to take away one's life.

She discussed the types of suicide-and said that though there are a number of people who commit suicide & die it is ten times that number who attempt suicide, and that was difinitely a **cry for help**, *and it was for us to lend a patient hearing, to be sensitive to the cry of help, in other words, to listen.*

Euthanasia

— Fr. Lawrence Abello S.J.

Euthanasia is any deliberate act or omission which by its nature, directly results in the death of a human being. The person is killed either by interfering with life processes or by denying essentials which could be assimilated without medical means. Death of the born person is brought about for the alleged good of the one killed or of society. Now we shall explain the terms of the definition.

BY ITS NATURE : The deliberate act of omission is of such a nature as to cause death. Thus, administering a normal dose of a sedative is not euthanasia even though it may accelerate death because a normal dose does not, by its nature, cause death.

DIRECTLY : the death of the person is the intent of the lethal action because the person is killed as a means to an end. If the person is killed by denying essentials like food, drink or air, the person should have been able to assimilate these essentials WITHOUT MEDICAL AIDS. The reason for making this restriction is that withdrawing or not administering essentials that can only be assimilated WITH MEDICAL MEANS (life suport systems) and which merely prolong the dying state is not immoral. We need not use "exrtaordinary" means to prolong life.

Withdrawing or administering essentials which can only be assimilated with medical means is not always immoral. This can be illustrated by the following example. Suppose that a dying man has to be fed every hour with an eye dropper. His wife, who alone can tend to him, finally is so exhausted that she fails to feed him for several hours during which period the the man dies. Since the man could not assimilate essentials without medical aids, witholding these essentials is not euthanasia and, in fact it is not immoral in this case as the life support system (feeding by an eye dropper) was merely prolonging the dying state. For instance, a teenager is brought into the emergency centre of a hospital. She has suffered extensive brain damage from a car accident. The doctor's prognosis is that very extensive cerebral surgery might have a ten

percent chance of enabling her to survive. Without surgery she will die in a few hours. Is such surgery proportionate or disproportionate? In other words, is the family morally obliged to request such surgery which would merely prolong the agony of dying? If the surgery merely prolongs the dying state, refusing such surgery is to accept our mortal condition and to allow nature ie. God to take its course ?

One must beware of euphemisms like ' mercy killing'' and ''putting to sleep'' which those wishing to legalize euthanasia will use. Likewise, as in the case of abortion. they will reso t to sophistry by appealing to the hardest cases. Thus they will pull at heart strings by presenting the case of an intensely suffering, moaning patient who, before becoming a ''vegetable'' expressed the desire ''to die with dignity'', or ''to be put to sleep'' and not merely to be allowed to die. This is a false compassion based on a completely secular philosophy of life. True compassion requires that one take into account the dying person's eternal destiny as the overriding consideration. A good end (alleviating temporal suffering) does not justify an intrinsically evil means (euthanasia). **One may not play God.**

Which is worse ? To blind or to abort the child ? Seen in terms of the real purpose of life. which is to pilgrimage towards eternal destiny–killing is much worse than blinding. The blind child can still walk. think, love, be loved and strive towards fulfilment. The dead child can neither hear, see, walk, love, be loved or do anything else, to prepare for the life beyond the right to life, is the foundation of all rights. I can live without seeing but I certainly cannot see without living. So abortion is the worst possible crime which is the reason why any Catholic who is an accomplice in an abortion is excommunicated.

Once a mother, abandoned by her husband and in tears about how to feed her children, wanted an abortion. To make her appreciate what she wanted to do the nurse pointed out to her that, to save money she ''should kill her 12 year old daughter rather than the youngest one''. After all, by killing the one in the womb she would save almost nothing for the next 2 years, whereas the biggest one is costing her the most to maintain. **So, going beyond emotions, one sees how unreasonable abortion really is.**

'Human Sexuality'

— Mrs. Phyllis Farias

"Sex is a sacred expression of one's innermost feelings"

Mrs. Phyllis Farias spoke on "The Need for Sex Education for Children". She said–Todays youth are bombarded with pornography with the result that the true meaning and essence of human sexuality is lost. Children are beset with doubts & anxieties, but do not find the correct door to tap at- Parents and teachers are themselves inhibited and can not deal with the topic or at times the facts are distorted. The overall effect of this distortion cum concealment attitude is to make the child ignorant, deceitful or timid.

Looking at the consequences of a lack of Sex Education-to name a few-irresponsible sexual relationships, poor sexual hygiene, difficulties in conjugal life, sexual preversions, sexual diseases, and abortion, one is firmly convinced that Sex Education is absolutely necessary But this education would have to start with the parents, on the help they could give their child. Problems arise because of a lack never an excess of accurate knowledge about their sexuality.

"Sexuality is not genitality" — "Sex Education is like Vaccination" It protects youth from the harmful media.

This talk was followed by a slide programme on Human Sexuality.

Mrs. Edith Kharshung and Mrs Mary Dora Blah of Shillong spoke very feelingly on the deteriorating state of values in the Youth. "The bow and arrow" symbol of bravery is used for gambling. Women once venerated are facing increasing violence

Celibacy as an Expression of Sexuality

— Fr A. Kackanath of Trivandrum

Celibacy comes from the Latin word 'caelebs' which means 'alone' Celibacy in the Christian sense does not mean 'living alone'. or being simply 'unmarried'. It is also distinct from being a single' person, bachelor or spinster. Celibate person is unmarried and intends to remain so, bound by a vow or promise to remain chaste.

How is Celibacy an expression of Sexuality ? We must see therefore the deepest meaning of sexuality in Christian understanding. Chastity is of 2 types, **Celibate Chastity** when the celibate does not use 'Genitality' and **Conjugal Chastity** when the celebates husband and wife are faithful and loyal and use gentitality for procreation and to bring love and life into the world.

Christian Understanding of Sexuality I

Sexual difference has been determined by the Creator and sexuality is a gift of God.

Relationship of man and woman reflects something of God's love, in its free giving of itself.

Man and woman are to complete each other through communication with the partner of the opposite sex.

In the partnership of man and woman there is no subordination or superiority.

The total surrender in the sexual act is termed by the 'knowing'. In this interpersonal relationship the partners reveal themselves in their deepest personal sphere of intimacy.

God communicates the power of procreation to man

With the proclamation of the Kingdom of God, the eschectological condition of man is emphasized to such an extent, that sexuality and its fulfilment in marriage no longer appears as the only normal way for man in this world, The way of virginity appears beside it as a genuine possibility.

Sexuality in itself includes the most basic urges of man for Love, Companionship, Mutual support and enjoyment, and procreation.

Anthropology views man and his sexuality in its entirety. Sexuality plays an important role in the growth of personality. Through the love of the partner, one goes beyond the limit of the partnership and reaches God. Sexuality grows from 'eros' to 'philia and from 'philia' to agape'. Through total self giving one receives knowledge and completion. So the aim of Sexuality enhances the development of the whole person and a celibate person can and should be wholly sexual.

PANEL 5 was a continuation of **"Human Sexuality"** with emphasis on **Masculinity and Femininity.** A young man from Bangalore–**Mr. C.N. Lakshmikanth spoke on Masculinity.** He spoke of the conflict a young student faces between traditional ideas and the attitudes to sex in the West. He spoke about the true attributes of Masculinity–and the youth's attitudes to women, and sex. He also spoke from conviction that he would only follow the Natural Family Planning Method when he married and would never advocate abortion even in the case of rape. A real man is never brutal to anyone.

Femininity–Dr. Sr. Pius a Psychiatrist spoke to the young post graduate students of Mar Ivanios College. Later, she addressed the gathering – and spoke on Femininity – mainly from the cases she has dealt with.

Fr. Rufus Pereira of Bombay dealt powerfully and beautifully with **Youth–their problems and the need for faith formation. Youth yearn for Love and Faith.**

We also had two very dedicated young people – **Mrs. Shanthi Baliah** and **Miss Uma Kanagala** – from **Holy Cross College–Trichy** speak to us on creating **"Respect for Handicapped People"**. They said that the problems handicapped people face are not only those caused by their disability but also those caused by a hostile world which threatens their very existence as human beings, and questions their right to life and happiness

Ways of creating respect for the handicapped

1. *Using appropriate language when referring to the handicapped Sensibility to word usage is very important so that individuality and dignity are not lost.*
2. *Following an Ecological approach to deviant behaviour – A person is handicapped by social attitudes.*
3. *Treating handicapped people respectfully in mass media.*
4. *Through deinstitutionalization – Institutions have become dumping grounds for the "human rubbish" that society does not want. These insititutions deprive the handicapped individuals of belongingness to a family, social contact etc.,*
5. *Through integrating in regular schools.*
6. *Through mainstreaming in vocational centers.*

Mrs. Mary Zaccharias of Alleppey and **Mrs. Lillian D'Morais of Cochin** dealt feeling with the topic of "Women of India" Mrs D'Morias spoke from her personal experience in helping young women with their problem and the destitute in homes, and was a shining example of what a woman can do.

On all the days – movies were screened and videos shown after conference hours. Some of the films screened were :

The Beginninig of Human Reproduction life.
Abortion – a woman's decision
The Silent Scream, the Answer etc.

"Educate a man and you educate an individual, educate a woman and you educate a generation".

Workshops

Workshops were conducted everyday on different topics. The following are some of the questions and recommendations.

Workshop – 1 — Creating Respect for Life

1. What strategies can you plan and use in your locality to promote respect for life ?
2. What role does the media play in craating respect for life ?
3. What are the different ways by which one can support and help, children and women in trouble ?
4. How would you create respect for life of the handicapped, old and infirm ?

Recommendations :

1. Create an awareness in schools and colleges by conducting Moral Science Class, seminars, workshops, etc.
2. Circulate private audio–visual aids like 'The Silent Scream' to educate and create an awareness.
3. Every school and college should have Counselling Centers – in order to give a helping hand.
4. The handicapped and old need love and understanding not pity. They should be taught to use their abilities to the maximum.

Workshop – 2 — Population :

Questions :

1. Is it true that there is a threat of population explosion in our country ? why and how ?

2. What is the most effective means to solve India's population ?
3. Would you advocate family planning to reduce population ?
   If so – Why ?
   If not – Why ?
4. Do you really think abortion has brought down the population of India ?

Recommendations :

1. There is a threat of population explosion but by education of the people – the so called all problem will look after itself.
2. The media, have to play their role for educating the masses on family size, nutrition, health, etc.
3. Natural family planning methods should be popularised – as artificial methods are not safe. Also N.F.P. brings about a good value system and understanding between husband and wife.
4. Abortion has not drastically brought down the population – legalisation of abortion should be condemned as a means of population control.

Workshop – 3 — Abortion and Human Sexuality

1. 'Sex is created by God. It is sacred'. Does society give sex its due respect? What role do you think you can play in this area ?
2. What are the benefits of educating our children in human sexuality rather than in contraception ?
3. What are the evil effects of pornography films – and books, obscene language in the life of people ?

4. Enumerate the effects of abortion on the mother.

5. In India female foetus abortions are more in number. Do you think there will be social implications of promoting one sex at the expense of the other. Will this not result in a lower respect for women.

Recommendations :

1. Seminars to be held for Parents first – before speaking to teenagers.

2. We should fight against pornographic films and literature – by writing letters etc.

3. Sex Education should be given in schools and colleges with moral values – it should not be only a biology class.

4. Teachers should be motivated and trained to guide students.

5. Abortion – has far reaching effects on the mother – women who go for an abortion should be told facts about how the abortion is conducted. and its after effects.

6. Abortion should never be allowed – even in case of rape – Abortion is taking away innocent life.

Thank You !

To all who helped make this Conference a Success.

To Ms. Phyllis Farias and Ms. Mary Paul for editing the the texts and organizing the Exhibition.

****

Become on active Member of the National Association of Respect for Life.

MH 2.5

Alcoholism

Dr.C.M.Francis
Director
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Drinking ihas been in existence from time immemorial but it was not much of a problem. Fermented juices were taken occasionally; the alcohol content was low. Drunkennes were isolated and socially looked down upon in our counntry.

Today, alcoholism is a major problem in the country. There are at least 3 million alcoholics in India. It is a problem for the individual (causing many diseases like cirolosis of liver and being a risk factor for other major diseases such as heart disease), the family (broken or unhappy families) and the society (crimes, fights, accidents and loss of productivity). It was because of the realization that alcoholism is a major problem that prohibition became a major policy of our Independence movement.

The problem of alcohol abuse is both urban and rural. The Indian Council of Medical Research study covering a number of urban centres including Bangalore found that 20% of urban consumers of alcohol are totally dependent on it.

Problem drinking is very high in industries, varying between 5 and 15%. With the large number of large scale industries in the public and private sectors in Bangalore, the problem is one of high concern. The economic costs of alcoholism are very substantial. In the developed countries, the Employees Assistance Programme for Alcoholism has been introduced successfully. It augurs well that the managements and trade unions in Bangalore are now seized of the problem.

Who is an alcoholic ?

A person who has become physically, physiologically or psychologically dependent on alcohol is an alcoholic. There is a compelling urge or craving for alcohol. The body adapts itself to alcohol. There is tolerance. There is dependence. Withdrawal produces symptoms which can be severe. Alcoholism is an illness, manifested by behavioural and clinical disorders. It is generally progressive but can be arrested.

Factors leading to alcohol abuse

Any type of person can become an alcoholic. Some people are more prone to become problem drinkers - alcoholic personality ? childhood delinquency ?

familial ? genetic ? Certain factors can precipitate alcohol abuse - stress, loss of job, death of abuse, sudden improvement in income. A pre-existing psychiatric problem like depression may lead to alcohol abuse.

Alcohol causes aggressive, silly behaviour. There is unsteadiness of gait and slurred speech. Difficulty is experienced in carrying out even simple tasks. Vision is impaired as also hearing. Alcohol can cause acute drowsiness; deep sleep and coma.

Early identification of problem drinkers

It is necessary to identify the "hidden alcoholic". Management is hopefully much easier at that stage than after the person has become a chronic alcoholic. There are many indicators available. No single indicator is absolute. But a composite group of indicators can be useful. Among them are psychological, clinical and laboratory manifestations.

1. Psychological

(i) The first one is a history, including drinking habits - frequencyy and quantity (how often ? how much?) Usually the person gives a reliable answer to the frequency but the quantity is often unreliable. Heavy drinking (about 60 g/day of ethanol) indicates problem drinking.

(ii) Increased tolerance to alcohol. The person needs more and more alcohol to get the same effect.

(iii) Drinking quickly, gulping the first drinks, skipping meals while drinking.

(iv) Concern or worry about drinking but unable to stop or reduce drinking, The family also gets worried about the drinking.

(v) Intellectual impairment. To a keen observer who knows the person well, this may be the first indicator.

(vi) Work impairment is an indicator.

(vii) Accident prone at the workplace and elsewhere

(viii) Absence from work

(ix) Change in friends, keeping company with heavy drinkers

2. Clinical

(i) Hand tremor may be one of the earliest symptoms.

(ii) Alcoholic fetor by day

(iii) Nausea and vomiting in the morning.

(iv) Signs and symptoms of acute or chronic pancreatitis

(v) Hepatomegaly and evidence of impairment of liver functions

(vi) Scars on the body (due to accidents and fights).

3. Laboratory

There are many markers which can point to alcoholism.

(i) Gamma gluttamyl transpetidase (GGT)

(ii) Serum glutamic ozaloaxetic transaminase (SGOT)

(iii) " alkaline phosphatase

(iv) " glutamic pyruvic transaminase (SGPT)

(v) Mean corpuscular volume (MCV)

(vi) Serum high density lipoprotein cholesterol (HDL -C)

(vii) Abnormal transferrin

(viii) Random blood alcohol level

Chronic alcoholism

Chronic alcoholism is indicated by

1.1. high/frequent consumption of alcohol
2. withdrawal symptoms; black outs
3. physical violence

2.1. battered children/wife
2. psychosomatic complaints, depression or anxiety in spouse
3. divorce/separation

3.1. impaired work performance
2. loss of sense of responsibility
3. absenteeism
4. prone to accidents

4.1. liver disease - cirhosis of liver
2. malnutrition

Counselling

Good counselling can be effective. It must emphasis responsibility; personal health, work and interpersonal relationships.

Educational material:

Good educational material, appropriate to the level of the person must be made available. Good literature must be produced as also audiovisuals.

Relaxation methods can help to allay tension and anxiety and contribute to better treatment.

Family therapy: Drinking behaviour might serve as an adaptive function for the individual or the family. Alcoholism could be a symptom of larger family problems. Family members can and should provide support to wean away the problem drinker. There sis also need to help the family. Counselling of the family members is needed.

Group therapy

Interaction with others who are also dependent on alcohol can help. Members of the group share and discuss their problems.

One successful group therapy was through Alcoholic Anonymous, founded in 1935 by Bill W, who was an alcoholic (real name: William Giffith Wilson). It arose from a long talk for hours with another alcoholic: Dr.Robert Smith. By talking together and sharing their weaknesses in giving up drinking, the two men found that the urge to drink passed off. Alcoholics anonymous has grown to at least a million members throughout the world.

Combining family and groups can be helpful. Multiple couples group therapy is to be tried. The difficulty is in finding couples and groups comparable in age, education, socio-economic status and severity of alcoholism.

Work therapy is worth trying as part of the total treatment.

Detoxification: During the acute stage, there is need for hospitalization. If there are complications, they must be treated. Management of the acute alcohol intoxication and the concomitant withdrawal syndrome will depend on

(i) patient's condition
(ii) nutritional status
(iii) severity of alcohol dependence, and
(iv) overall medical evaluation.

Treatment of complications

The most important and direct morbidity caused by alcohol is cirrhosis of the liver. Mortality due to cirrhosis in different countries is closely related to the amount of alcohol consumed, irrespective of the type of beverage. The risk factor for development of cirrhosis is given by the product of the average daily consumption of alcohol multiplied by the period of consumption at that level. Fatty degeneration of liver and alcoholic hepatitis may be seen.

Pancreatitis (acute and chronic) can be caused by alcohol. Gastritis is another clinical manifestation. Anaemia and clotting disorde s can occur. Neurological diseases affecting central and peripheral nervous system may be seen. The heart may be affected by cardiomyopathy. Vitamin deficiencies may occur.

Pharmacotherapy

Treatment with drugs does not have an important place in the management of alcoholism. In the initial stages, there may be a place for anxiolytic drugs and antidepressants. So also drugs are useful to control withdrawal symptoms.

One drug which is useful is disulfiram (antabuse). It causes an aversion reaction when alcohol is taken. Disulfiram blocks the oxidation of alcohol at the accetaldelyde stage, raising its concentration in the blood by 5-10 times, and causes reaction. 125 - 250 mg of the drug is administered per day or once in 3 days. (the effect often lasts for a week). Taking as little as 7 ml of alcohol can bring about the reaction. Care should be taken as the side-effects and contra-indications are many and the reaction can be severe.

Disulfiram action was discovered accidentally, Two Danish scientists took the drug themselves to assess its safety as a vermifuge. While on disulfiram, they

went to a cocktail party with disastrous results. They inferred that the drug might be useful in preventing alcohol consumption.

Other drugs like calcium carbamide and metronidazole and other aversion techniques are being tried.

Research

Research is needed if we are to solve our problems in the future. "If you do not think of the future, you cannot have one". There are many areas of research.

1. Survey of alcohol use - licit and illicit
   - youth; different socio-economic groups
   - employed persons
   - industries
   - extent of alcoholism in the population

2. Control measures - legal
   - educational
   - social
   - limiting use of alcohol
   - limiting problems arousing out of use of alcohol.
   - cause of spread of alcoholism.

3. Preventing alcohol abuse
   - factors governing use of alcohol.

4. Identifying the problem drinker - development of markers of alcohol consumption

5. Adverse effects of alcohol use - individual
   - family
   - society
   - at the work place

6. Mechanism of tolerance to alcohol

7. Drinking and accidents - on the roads
   - in the factory

8, Alcohol and diseases	- liver
	- cardiac
	- neurological
	- psychiatric
9. Treatment	- psychological
	- pharmacological
	- individual
	- family
	- group
	- low cost interventions
10. Follow-up	- Evaluation of recovery
	- Prevention of relapses
	- Employee assistance programmes

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Clinical Note

Phencyclidine Ingestion: Drug Abuse and Psychosis

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Abstract

Phencyclidine (PCP) is a popular illicit drug often misrepresented as some other hallucinogenic substance and distributed in widely varying dosage forms and strengths. Users of hallucinogenic drugs may present with unintentional PCP overdoses. Toxicological laboratory analyses are essential to establish the diagnosis. In nine admitted overdose patients, the consciousness level ranged from alert to comatose on presentation, and all showed a prolonged recovery phase with agitation and toxic psychosis. Severe behavior disorder, paranoid ideation, and amnesia for the entire period of in-hospital stay are characteristic. In very high dose patients, shallow respiratory excursions and periods of apnoea and cyanosis coincided with generalized extensor spasm and spasm of neck muscles. Excessive bronchial secretions, gross ataxia, opisthotonic posturing, and grimacing occur. PCP toxic psychosis should be considered in drug-abusing patients presenting with schizophrenic-like symptoms, psychosis, or other bizarre behavior, whether or not they admit to taking PCP.

INTRODUCTION

Phencyclidine is a drug better known as PCP, a designation which is derived from its chemical name 1-(1-phenylcyclohexyl)piperidine. It is structurally related to the clinically useful anaesthetic agent ketamine and was introduced into clinical trials in the late 1950s as an intravenous anaesthetic with potent analgesic activity (Greifenstein and DeVault, 1958; Luby et al., 1959; Meyer et al., 1959). Despite the findings that it was an effective anaesthetic agent for superficial surgery (Greifenstein and DeVault, 1958), clinical testing was discontinued in 1965 because of a high incidence of adverse effects including a complex spectrum of sensory and cognitive effects characterized by alteration in body image with feelings of depersonalization, delusional and illusional experiences, a sense of isolation sometimes associated with intensification of dependency feelings, disorganization of thought, drowsiness, apathy, and euphoria. Repetitive motor behavior, anxiety, and depression were encountered occasionally. The duration of these effects after PCP anaesthesia ranged from a few hours to 4 d, and patients generally experienced amnesia for events which occurred after they regained consciousness (Greifenstein and DeVault, 1958). The effects of an acute dose of PCP have been likened to a sensory deprivation syndrome (Luby et al., 1959; Meyer et al., 1959).

In 1967 a PCP-containing tablet known as the "PeaCe Pill" appeared in San Francisco and within a year this drug was widely available in the eastern United States under the name "hog" (Londgren et al., 1969). Since that time

it has become a common drug on the illicit market throughout North America, being found frequently in material alleged to contain some other drug(s) (Baselt et al., 1972; Brown and Malone, 1973; Marshman and Gibbins, 1970; Schnoll and Vogel, 1971). The drug is therefore often ingested unintentionally.

During the past 4 years our Emergency Department has seen numerous mild PCP intoxications. Patients presenting with mild impairment were observed in a quiet room in the Emergency Department and the "talking down approach" was very effective in controlling the manifestations of toxic psychosis. Diazepam (10 mg orally) was used to sedate some patients. The majority of patients were discharged. The minority of patients who did not respond over a period of 8 h to the above management were admitted. The nine admitted patients comprising this report can present (to the unsuspecting physician) a bewildering clinical picture easily misdiagnosed as a primary psychosis. The clinical characteristics and course of nine patients admitted for PCP overdose are presented in Tables 1, 2, and 3. PCP was detected qualitatively by gas chromatographic analysis in the urine and/or blood of all nine patients (Marshman et al., 1976), although only *three* patients reported use of this drug.

CASE REPORTS

Patient 2

A 33-year-old male allegedly took tetrahydrocannabinol (THC), 1 g, 2 d prior to presenting in a catatonic, mute state at another hospital's Emergency Department. On examination at the time of transfer to the Clinical Institute, he was found to be alert with roving eye movements but showed no nystagmus, normal pupils, decreased response to pain sensation, catatonic rigidity, increased deep tendon reflexes, and flexor plantar responses. His heart rate was 88/min, blood pressure was 140/90 mmHg, respiratory rate and temperature were normal, and he showed excessive salivation. The catatonic mute state lasted 4 h and was followed by a period characterized by staring into space, making clicking noises with his tongue, echolalia, inappropriate monosyllabic answers, and euphoria. He was confused, disorientated, agitated, and hallucinating; he frequently assumed bizarre postures and showed a short attention span and profound sleep disturbance. Urine and blood samples on admission were positive only for PCP. He was given diazepam (10 mg) intravenously, q6h.

By the sixth day he was orientated in time and place and his mental state had improved significantly. At the end of 9 d in hospital he had completely recovered and showed no evidence of toxic psychosis. He was amnesic for the entire period of in-hospital stay. Urine and blood remained positive for PCP for nine consecutive days.

Clinical Histories of Nine Cases of Phencyclidine Toxic Psychosis

5	6	7	8	9
17/M	18/F	18/M	20/M	18/M
Amphetamine, heroin, LSD, PCP	LSD, THC, marijuana, hashish, mescaline	LSD, amphetamine, heroin, marijuana, PCP	LSD, amphetamine, heroin, opium, marijuana	Marijuana, LSD, mescaline, THC
PCP (6 tablets)	Mescaline (5–7 g)	Cocaine, amphetamine	THC (31 tablets)	THC
3 d	1 h	3 d	1–2 h	5–6 h
4 d	4 d	8 d	11 d	13 d

bronchial secretions required frequent suctioning. Chlorpromazine (100 mg) orally, q6h, was given to control his psychotic behavior.

On the fifth day he was depressed and suicidal and over the next 2 to 3 d he continued to be destructive and irrational. Thereafter, gradual improvement was noted. By the tenth day his speech was slow and deliberate and although he was unable to initiate conversation, he was polite and cooperative. On the twelfth day he had completely recovered, showing no evident psychotic signs and chlorpromazine was discontinued. He remains amnesic to the entire period of toxic psychosis.

DISCUSSION

The wide discrepancy between the patients' description of drugs abused and his/her actual street drug use is consistent with the findings of various street drug analysis programs. For example, during the period 1971-1976 PCP was the drug most commonly encountered in the street drug analysis program of the Addiction Research Foundation of Ontario. The samples had been voluntarily submitted to the Ontario Addiction Research Foundation for qualitative analysis by people not associated with law enforcement. Approximately 22% of all drug-containing samples (N = 294) examined by the laboratory contained PCP; of these, 26% were combinations of PCP with some other drugs, commonly

Table 2

Clinical Manifestations of Nine Cases of Phencyclidine Toxic Psychosis

Patient	1	2	3	4	5	6	7	8	9
Agitation	+	+	+	+	+	+	+	+	+
Confusion and disorientation	+	+	+	+		+	+	+	+
Hallucinations		+			+	+	+	+	+
Delusions					+	+			
Staring into space		+	+	+			+	+	+
Short attention span	+	+	+						
Alterations in communicative ability:									
Difficulty in verbalizing						+	+	+	+
Slurred speech	+					+		+	+
Echolalia	+	+					+	+	+
Catatonic mute state		+	+						
Behavior disorder		+		+			+	+	+
Paranoid ideation	+				+	+		+	
Depression	+					+		+	+
Amnesia for period of psychosis		+	+	+			+	+	+

LSD. Only 11% of the PCP-containing samples were alleged by the submitting physician (or patient) to contain PCP; the remainder were described as THC, mescaline (or peyote), MDA (i.e., methylene-dioxyamphetamine), LSD, psilocybin, cocaine, and less frequently as some other drug or drug combination. Tablets, powders, and capsules in a wide range of colors were the most frequently encountered dosage forms, and in some cases it was evident that capsules intended for legitimate pharmaceutical preparations had been diverted or emptied of their original contents and PCP had been introduced for street sale. Some of the street drug preparations had the form of yellow brown gummy materials or crystalline chunks, forms which suggest "illicit" synthesis. Occasionally the drug was encountered in solutions or in admixture with mushroom material (either decaying or dried) or green leaf material, sometimes marijuana. Quantiative assays of a random sample of these products revealed PCP contents ranging from 2.2 to 9.9 mg for tablets and 0.4 to 81.0 mg for capsules.

With widespread availability and the variation in dose level of PCP, it is not surprising that the recent literature contains several clinical reports of acute states of intoxication associated with nonmedical ingestion of the drug, involving not only teenagers and adults (Burns et al., 1975; Eastman and Cohen, 1975; Kessler et al., 1974; Liden et al., 1975a, 1975b; Lin et al., 1975; Marshman et al., 1976; Reed et al., 1972; Reynolds, 1971; Stein, 1973; Tong et al., 1975) but also young children whose ingestion of the drug was accidental (Burns et al., 1975; Liden et al., 1975a, 1975b; Lin et al., 1975). Despite the "street" impression that PCP is a benign recreational chemical, several recent reports of PCP-associated deaths confirm its status as a drug of substantial risk (Burns et al.,

Table 3

Abnormal Physical Signs in Nine Cases of Phencyclidine Overdose

Patient	1	2	3	4	5	6	7	8	9
Level of consciousness on admission	Drowsy	Alert	Alert	Alert	Alert	Coma	Coma	Coma	Coma
Intermittent apnoea and cyanosis	+		+			+		+	+
Excessive bronchial secretions						+		+	+
Blood pressure on admission	140/100	140/90	140/90	130/90	130/90	190/100	130/90	150/100	140/90
Nystagmus	+					+	+		+
Visual disturbance						+			+
Ataxia	+		+			+	+		+
Catatonic signs		+	+						
Neck rigidity								+	
Generalized rigidity and opisthotonic posturing						+	+	+	
Grimacing and trismus						+	+	+	+
Athetotic movements	+						+		
Decreased response to pain		+				+	+	+	+
Autonomic changes:									
Hypersalivation		+	+				+	+	+
Lacrimation			+			+		+	

1975; Eastman and Cohen, 1975; Kessler et al., 1974; Lin et al., 1975; Reed et al., 1972; Reynolds, 1971). The clinical manifestations of PCP toxic psychosis seen in our patients (Table 2) are consistent with previous reports (Burns et al., 1975; Liden et al., 1975b; Stein, 1973; Tong et al., 1975). The abnormal physical findings (Table 3) in all nine cases are typical of intoxication with moderately high (Patients 1–5) to very high (Patients 6–9) doses of PCP.

When present, coma lasted 4–6 h, and two of these patients had shallow respirations during the period of coma. Periods of apnoea and cyanosis occurred which coincided with neck muscle spasms (including laryngeal spasms) and generalized extensor spasms. Pooling of excessive bronchial secretions interfered with normal ventilation in unconscious patients, but in alert patients these secretions were easily expectorated and constant spitting was a characteristic feature.

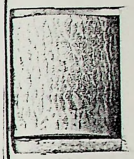
Even in the presence of a normal respiratory rate, PCP overdose patients must be closely watched in the first 12–18 h for apnoea and cyanosis which may be associated with localized or generalized muscle spasm. Unless the history suggests very recent ingestion of a large number of tablets or capsules, gastric lavage is contraindicated in the alert patient as it may induce laryngeal spasm and aspiration of emesis. Respiratory acidosis, which occurred in two of the nine cases, was treated by adequate ventilation and by frequent suction of excessive secretions. Intubation and ventilatory assistance were not indicated in any of our cases.

Nystagmus, transient photopsia and blurred vision, gross ataxia, and other motor system abnormalities (Table 3) observed in these patients were consistent with previous reports (Burns et al., 1975; Eastman and Cohen, 1975; Liden et al., 1975a, 1975b; Stein, 1973; Tong et al., 1975). Opisthotonic posturing and generalized rigidity were present in three patients who were comatose, but seizures did not occur (cf. Burns et al., 1975; Liden et al., 1975a). Although opisthotonus has been previously noted in an adult patient (Liden et al., 1975a), it has been more commonly reported in children (Burns et al., 1975; Liden et al., 1975a, 1975b). Decreased response to pain was observed in most patients during the alert state.

Our treatment approach in all patients support the observations that interaction with staff causes exacerbation of the drug-induced problems (Stein, 1973; Tong et al., 1975) and that avoiding even minimal stimuli to the patient lessens severity of the toxic psychosis. Patients uncontrolled by symptomatic treatment should receive medication. Oral or intravenous diazepam was useful in reducing agitation and muscle spasm in Patients 2, 4, 6, and 7. Chlorpromazine was used in the management of more severely psychotic cases (Patients 5, 8, and 9).

Phencyclidine is a commonly available street drug frequently mislabeled as some other substance and marketed in a wide range of doses. The staff in

Emergency Departments should be trained to consider PCP toxicity in patients presenting with schizophrenic-like symptoms, delirium, psychosis, or in fact in a young drug user with any form of bizarre behavior. The slow recovery is largely the result of slow elimination of PCP (half-life approximately 15 h) (Marshamn et al., 1976). Toxicological laboratory findings were particularly valuable in facilitating diagnosis when the patient presented with psychosis and/or abnormal neurological and systemic manifestations.



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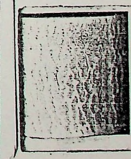

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ALCOHOLISM & DRUG ADDICTION - THE CHURCH'S RESPONSIBILITY

(REV. J.D. SOLOMON)

This paper is a summary of the presentations made by very competent leaders at the conference on the above theme held in Madras during 1 - 3 March 1988, under the auspices of the CSI Council for Healing Ministry. The first section, 'church's response' is rather a statement on the church's understanding of, and attitude to the problem. The nature of the problem is an expression of the understanding of what 'alcoholism and addiction' mean in reality, so that our approach can also be realistic. The causes indicate the areas wherein, and levels at which the community must have preventive and therapeutic involvement. The last section, 'plan of action' is the recommendations of the conference for immediate implementation by the dioceses. The section on treatment is not included in this report.

Though not one and the same, alcoholism and addiction are used here almost as synonyms.

THE CHURCH'S RESPONSE:

We acknowledge that alcoholism and drug addiction are assuming alarming proportions affecting the physical, psychological, socio-economic and spiritual well-being of the individual. Addiction destroys not only the individual, but also his/her own family and the community at various level. The church recognises the fact that the epidemic spread of addiction could destroy all progress and cut at the very root of human welfare.

Having recognised the frightening spread of the burning problem throughout the world, the church has the responsibility of combating this devastating trend.

There is an interplay of various factors that lead to problem drinking and an industrial society tends to provide potential situations that facilitate such an interaction. The sole responsibility of a person becoming alcoholic may ultimately rest on the individual himself; but a fuller understanding of the nature of the problem warrants the recognition of various socio-economic-cultural forces. Hence the church's attitude can never be judgmental but more acceptive, compassionate, constructive and reformative.

..2/-

The church should encourage total abstinence. We would urge all church leaders, including the laity, to set an example to the flock in this regard.

From the Biblical point-of-view all of God's creation is good, but with the possibility of turning into evil at human hand. Alcohol and drugs are human products. Up to a degree these human products can be put to positive use, as in the case of medicine, for example. But abusive practice brings in evil. It ultimately distorts the human personality and destroys the image of God in man and his tremendous potentialities. Not only the individual, but his community and society at large also suffer from the destruction. This is going quite contrary to the will of a Father who is involved in bringing His Kingdom here on earth.

Hence we urge the church to face the issue as in a crisis and exercise its Ministry of bringing life, hope and liberation to the unfortunate victims and their families. The church must use all its spiritual resources, as well as medical, psychological and social-work skills through preventive, therapeutic rehabilitative actions, thus communicate and witness to the Abundant Life offered in Jesus Christ. The church must mobilise all its resources and engage in appropriate planning, education, prevention and treatment. While a minimum of competent institutional facilities has to be developed, our congregations must be equipped for the larger and wider role of building up a wholesome society, functioning basically as Healing, Caring and Prophetic Community and thus participate in the Holy Spirit with the Father in making His Kingdom a reality.

NATURE OF THE PROBLEM:

From indegenous literature and the Bible (Genesis 9:20 - 21) it is to be understood that excessive drinking is not anything new or modern. From time immemorial intoxication was not unknown in almost every rate and hence it may be said that 'Alcoholism' is an age-old problem. Yet the alarming proportion in which it is spreading today, like an epidemic, calls for immediate actions. It has become a global phenomenon. Behind almost every murder, crime, burglary, rape and many physical illness the influence of alcohol is observed. It is now spreading into all sections of society, even into the remote villages and different age-groups, destroying many individuals, families and even community. Alcoholism leads to the person's physical,emotional

socio-economic and spiritual destruction. The growing number on absenteeism in schools, colleges, factories and institutions is an indication of the powerful influence of problem drinking. The percentage of drug-addicts even among school children is increasing. The wasting of economic resources on the substance ruins the whole family and the worst affected are the women and children of the lower-income group.

'Alcoholism is a suicide', said Melanie Klein, as it leads to a total personality destruction. Chronic cases lead to such psychiatric problems like Delerium, dementia, paranoia and even psychosis. An alcoholic lives in a world of sever tension and self-torture. Loss of self-esteem, feeling of intense torture, sense of powerlessness and alienation from everyone close to him lead to a total emotional deprivation. He is almost a loner suffering from a sense of self-condemnation and guilt. Frequent breaking of repeated promises makes him more and more guilty. Full of anger, hostility and resentment, he may turn to aggressive attacks or sometimes drift into a dreadful silence. Employing intellectual arguments he may want to rationalise his own actions.

'Denial' is a very common defence-mechanism an alcoholic would resort to and that is a safety-valve from his total mental breakdown. His own actions are justified and the whole blame is thrown on someone else. Suspicion (of the spouse) is often presented as an excuse for excessive drinking.

These actions are usually looked upon by the society as 'bad', or'wicked' or 'evil' behaviour of an Alcoholic. In fact, alcoholism is a disease, expressed in such symptoms as described above. It is an illness which has to be treated and can be treated, and prevented. It is also to be understood as a health problem.

Alcoholism is not only a personal but also familiar problem. The family also begins to loose hope and behave neurotically, but without the use of alcohol. The whole network of relationship between the husband and wife, parents and children and between the siblings is disrupted. The family suffers from a sense of social ostracism and would want to contain the total mysery, as far as possible, within the family itself, upto the breaking point,for fear of the stigma.

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THE CAUSES - FACTORS THAT CONTRIBUTE TO THE DISEASE:

There is no one, single, clearly identified cause that contribute to the development of problem-drinking. Living under the same potentially depriving and frustrating environment, one may end up on alcoholism while another living under the same situation need not. So the causes are multi-factorial; there is an interplay of more than one factor, sociological, biological, psychological and environmental. The problem can be identified symptom-wise, but prognosis is never clear. The causes are so complex and often include the following:

1. Change in the sociological pattern, a fast changing society amounting to severe competition and confusion of roles and conflict of values; restrictive parents and freedom-loving children; conflicting parental authority producing confusion and anxiety among the children; lack of recreational facility, not only to the young, and opportunities for creative use of leisure.
2. Easy availability of substance; increase in the supply resulting in an increasing demand. The alluring effect of mass-communication and advertisement. Transnational companies competing each other in production, distribution, and marketing; subtle influence of drug-pushers; growth of illicit brewing as a cottage industry; governments finding it impossible to check on production and enforce existing law, wanting the support of big barrel guns.
3. Genetic factors are seen to play a part in some instances.
4. Personality factors; alcoholism is an anti-developmental activity. Non-conforming personality seems to drift into more easily.
5. Psychological factors: lack of love, sense of insecurity, feeling of inadequacy, depression and frustration; disorganisation and depression within the family; a dominant spouse.
6. No particular socio-economic group is more prone to addiction. The neo-rich seems to want to imitate those up in the social ladder; sudden economic growth and possession of power.

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7. Certain groups seem to be more vulnerable to addiction, the last born or first born; persons with early parental loss; young or middle-aged; men more than women (8:1 in India, 3:1 in the West).

Findings of a study identifies the following factors which lead to addiction:

Pleasure
Peer-pressure
Curiosity
Drifting away from God/religion
Imitation of friend or adult
Initiation by a friend, a 'well-wisher'.

Alcohol is an answer, an alcoholic has found for his pent-up emotional tensions, continuous deprivation and uncertain future.

Any attempt to counteract the onslaughts of these influences has to be inclusive and eclectic.

CHURCH'S PLAN OF ACTION:

Intervention:

Approach the alcoholic as a person with an illness and avoid branding him as a sinner. Reach out to him as a brother with a health problem; Accept him as he is. An alcoholic cannot accept himself. Listen to him patiently and creatively, communicating forgiveness and hope and be optimistic. Remember that time, patience, training and various skills are needed, along with prayer. Persons involved in fighting against alcohol and addiction are confronting a formidable destructive force and hence must build-up one's own spiritual resources. Intervening in the life of an alcoholic and his family is a great privilege, but difficult and responsible. Atmost respectability has to be maintained.

Interview:

After a few interviews with the alcoholic by an understanding individual or a small group, he might express a desire to undergo a treatment process. Let us remember that motivation cannot be thrust down on anybody from outside. Sometime it is the inescapable crisit that one has finally come to that motivates him to hope for a change. Very often early indentification and treatment facilitate better results.

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Treatment:

When he has committed himself to undergo treatment for modification, he can be guided to a centre, where total treatment is accepted. The medical aspect of the treatment called 'Detoxification' for a period of 2 - 3 weeks is entirely under professional hands. It is a time when the family members need a lot of support.

Recovery& Rehabilitation:

What goes on during this period - the longer one - is most important. Many experts think that treatment really starts at this stage. Voluntary groups, self-help groups, Alcoholic Anonymous are of tremendous help. Personality and attitudinal change occurs during this time. The consequences, economic, social etc., have to be rectified. Gradually his self-esteem and hope is regained and is now launching out as though into a new world. His leisure and new-found energy has to be directed and utilised; he must be kept engaged. A supportive group can increase family resources to cope up with the changed situation, encouraging communication and mutual sharing. Keep the pastoral concern to continue even at times of relapse and failures.

Prevention:

- strengthen each family to provide mutual love and Christian nurture. Help to build-up the self-esteem of each person, each child. Keep open the communication channels, and uphold higher values in life.
- the church is a larger family that should enrich the functioning of single families, where family goals are strengthened and reinforced and family resources supplemented. Opportunities for expression, entertainment, mental health and emotional maturity should be offered in any church. Never become stagnant, but keep on remodelling. Help the your to develop resistance to temptations and will-power to make better choices and responsible use of freedom.
- share the same goals with the Sunday School, Youth Fellowship, Women's Fellowship and Men's Fellowship. Encourage neighbourhood groups, Koinonia (prayer, Bible study and action) groups; encourage and enjoy being a therapeutic group. Increase positive pastime activities such as,

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play groups, summer camps, excursions, hyking, hunting, fishing, sports and games, literary clubs,dinner parties and Bible-study clubs.

- reach out to the vulnerable group through schools colleges, Y.M.C.A. and similar organisations. Prepare and distribute educational literature on the subject and collect stores of recovering alcoholics, stories about their conversions and new-birth.
- from the local congregation spread to the district/area and the diocese.

Awareness building:

* this can be done within and outside the church. Collect correct information, scientific facts and figures on alcohol and drugs and their long-term ill-effects on individuals and society and desseminate such information.
* organise study conferences.
* make use of the Pulpit.
* make use of the available audio-visual material. Prepare rnew relevant visual aids as teaching material; employ drama, stories and charts.
* help to change the hostile attitude of the society and create a healthy one instead; counteract the subtle massive destructive profit-oriented advertisement campaign.
* mobilise public support for promoting proper laws by the government.

TRAINING:

Recruit volunteers from different professions and age-groups and train them in,

- providing necessary skills and attitude and understanding;
- provide short-term medical training for such Doctors and Nurses;
- offer short-term counselling courses;
- develop Biblical perspectives and spiritual resources;

The Council for Healing Ministry initially will provide training in all the above areas with a view to develop 2-3 treatment centres in each region incorporating hospitals and congregations.

PART - II

ALCOHOL EDUCATION IN A COMMUNITY (CLUB)

By R. Srinivasulu (P.G. D.H.E. Trainee) June 30, 1990

Supervisory Field Training Project Report
Submitted to
M.G.R. Medical University Madras
Thiru'
Deptt. H.E. NIMHANS Bilore-29
&
Gandhigram Institute of Rural Health
& Family Welfare Trust,
P.O. Ambathurai R.S.
DGM District, TAMIL-NADU PIN: 624309

Part - I - H.E. in Hospital situation - Epilepsy Educ*.

IN THE LONG RUN

We drank for happiness and became unhappy.
We drank for joy and became miserable.
We drank for sociability and became argumentative.
We drank for friendship and made enemies.
We drank for sleep and woke up without sleep.
We drank for strength and felt weak.
We drank to feel better, and acquired health problems.
We drank for relaxation and got the shakes.
We drank for bravery and became afraid.
We drank for confidence and became doubtful.
We drank to make conversation easier and slurred our speech.
We drank to feel heavenly and ended up feeling like hell.
We drank to forget and were forever haunted.
We drank for freedom and became slaves.
We drank to forget problems and saw them multiply.
We drank to cope with life.

AND WHERE ARE WE NOW?

P A R T - II

ALCOHOL EDUCATION IN A COMMUNITY (SLUM AREA)

CHAPTER. I

INTRODUCTION:

Alcohol abuse is widespread in slums. If the magnitude and dimensions of the problem of alcohol abuse could be assessed, it may be found to be a major public health and social problem. After extensive research it has now been established that "addiction is a disease". It is a very serious disease because it affects the

- Physical
- Mental
- Social and
- Spiritual well being

of people who abuse alcohol and become addicts. There is also the danger of many young people falling a prey to the 'disease' due to the environment.

The question before the health education specialists is "what can be done to tackle the problem of alcohol abuse through education? " To plan, implement and evaluate any educational programme on alcohol abuse in a community setting - that too in a slum area, is a challenging job because of:

1. The very nature and magnitude of the problem.
2. Hostility one will confront from the vested interests (it is left to one's guess on who are they?)
3. People affected and interested ask a difficult question:

> " Why can't you cure the root cause of the disease (availability of alcohol) rather spending your time and energy going on treating the disease? "

The health workers of women voice (a voluntary association) working in the slums of Bangalore identified 'alcohol abuse' as a major problem affecting income, health and family & social life of the people. The women and children were the worst affected because of alcohol abuse by the husband/father. The workers wanted to tackle this problem on their own but in vain. Then the women's voice got in touch with the Department of Health Education seeking a programme to tackle the problem. The Department was contemplating on working out an educational programme for the women's voice and give its expertise help.

My Supervisory Field Training Placement at NIMHANS at this juncture, gave me an opportunity to work out an educational programme in a slum area as a pilot project with the support of the Department of Health Education and Women's Voice.

ABOUT WOMEN'S VOICE:

Women's voice was established in the year 1980, and was registered under the Karnataka Societies Registration Act in the year 1982, with the primary aim of working towards the integrated development of all women, especially among the poorer women from the slums and the unorganised sector of work.

The Women's Voice Organises, supports and develop activities and programmes for the promotion of poorer sections in general and women in particular in Bangalore City. The work has gained momentum, to the level, that the women of these sections participate fully in the activities and take an active leadership in the field of education, health and employment aspiring to work towards a better tomorrow.

The Women's Voice educates women through regular meetings, discussions, seminars, conferences, leadership training programmes and also through cultural media, audio visual aids to train and equip literates as well as illeterate women in different aspects of life particularly in the field of education, community health, self employment, legal education, child care etc.,

OBJECTIVE:

To work out an educational programme on alcohol to be implemented in slum areas by the Women's Voice with the expertise of the Department of Health Education, NIMHANS.

CHAPTER .II

DIAGNOSTIC PHASE:

On 24th May 1990, a meeting was held at the Women's Voice Office, St.Mark's Road, Bangalore -560 012 with the 11 health workers. The health workers are women from the Community (slums) with no or low educational level. Their technical knowledge on health is due to the training given to them and through orientation by their health co-ordinator and medical consultant during periodical meetings and field visits. The Organising Secretary of Women's Voice and their Medical Consultant, and Health Co-ordinator and I participated.

Faculty of the Department of Health Education, NIMHANS

The meeting focussed on various aspects of the problem of alcohol abuse such as:

- who drinks?
- why people drink?
- what they drink?
- what are the main occupations & income levels?
- How much is spent on alcohol?
- What are the other problems in the family?
- What the women in the area feel about it?

It was agreed to start in one slum in the first instance. Ramanna Gardens (slum) was selected for working out an educational programme on alcohol.

I prepared a Community diagnosis schedule to collect information from two female health workers of the Ramanna Gardens (Ages 35 and 27). A copy of the schedule is given in Annexure.IV.

On 28th May 1990, I made my first visit to Ramanna Gardens along with my co-trainee. Subsequently, I made visits to the slum on a regular basis.

ABOUT RAMANNA GARDENS (SLUM):

LOCATION: Ramanna Gardens (Slum) is situated 6 kms from NIMHANS and 1 km from the Corporation Office. It is in between J.C.Road, New Mission Road and Lalbagh Road. A spot map is given in Annexure.V.

HOUSES & SANITARY CONDITIONS: There are 264 houses and the population is about 1600. People live in very insanitory conditions. The so called houses are continuous without any space in between. Space inside the house varies from 30 sq.ft., to 80 sq.ft., Houses have a single door and no windows. Height of some houses are less than 5 ft., The lanes between the houses are narrow and the width varies from 3 ft., to 5 ft.,

HISTORY: The slum is reckoned to be 40 years old. People from Tamilnadu, mainly from parts of North Arcot, South Arcot and Salem Districts who came for construction work of Vidhana Soudha settled here and the slum came into existence.

PEOPLE: Most of the people speak Tamil. In about 25 families, they speak Kannada, Telugu and Urdu. Men work as construction workers, headloaders, cartpullers, vendors, drivers, painters etc., Women (not all women work) work as construction workers, house servants, vegetable vendors, flower vendors, Agarbathi makers, etc., Majority of the people are Harijans. Most of the people are illeterates or have a few years of schooling. The maximum educational level was P.U.C., The daily income of males vary from Rs.40/- to Rs.80/- according to nature of work. The working women earn anywhere between Rs.10/- to Rs.40/- per day.

INSTITUTIONS AND ORGANISATIONS: The following are functioning organisations:

1. Dalit Harijana Seva Sangha
2. Karnataka People's Social Welfare Association.
3. Ramanna Gardens People's Social Welfare Association (Youths Association)

4. One Anganwadi

5. Christian Children's Fund Centre

ALCOHOL ABUSE IN THE SLUM:

Alcohol abuse is drinking that impairs one's ability to function.

From the Community health survey it was found that ~~about~~ about 70 - 80% of the families have an alcohol abuser. During group discussions with women it was found that there were alcoholic abusers in 17 out of 23 families. Some women were also alcoholics. It was also revealed that invariably 50% of the income of such abusers was spent on alcoholic drinks (mostly arrack/illicit arrack).

CHAPTER. III

PLANNING PHASE:

On studying various factors it was found that the Women's Voice had the necessary workers already working in the community and with the community and Department of Health Education, NIMHANS could train, give consultancy services etc., A on Alcohol Education. Expertise of NIMHANS combined with the field organisation of Women's Voice was thought to be a judicious combination to implement an Alcohol Education Programme in the slums.

On discussion with the Women's Voice and in consultation with the Department of Health Education, it was decided to impart a training programme for the Health Workers of the Women's Voice in order to strengthen them on 'alcohol education'.

CHAPTER .IM

I M P L E M E N T A T I O N

The following lesson plan was prepared for the training. It was discussed with the Professor and finalised after necessary additions:

LESSON PLAN

1. TOPIC : Alcohol and addiction
2. TRAINEES (TO WHOM) : Health workers of the Women's Voice.
3. TRAINER (BY WHOM) : D.H.E., Trainee on S.P.T.,
4. DURATION : One hour thirty minutes.
5. OBJECTIVE : After the training session, the health workers will be tell.

- Alcohol content in beer, toddy, arrack, brandy, whisky and rum.
- Some facts on alcohol like absorption, detoxification, effects, hangover.
- Addiction and addiction is a disease.
- Three phases of the disease.
- Regular excessive intake of alcohol affects physical and mental health.

- The disease of addiction requires medical and psychological treatment.

6. EDUCATIONAL METHOD. : Lecture - cum - discussion.

7. EDUCATIONAL AIDS. : (i) Transparancies.
(ii) Video film
(iii) Poster designs.

8. CONTENT:

(a) Introduction: The problem of alcoholism is widespread in the slums. The individual's physical and mental health , his family and society suffer. There is the danger of youngsters picking up the habit because of the environment. Since addiction is a disease, it should be understood properly as one which requires medical and psychological treatment and support from the family and society.

(b) Subject Matter:

Types of drinks and alcohol constent. : Beer, Toddy, Arrack, Wine, Whisky, Brandy, Rum.
: 8% , 8% , 55%, 15%, 40%, 40%, 40%.

Absorption : Alcohol is directly absorbed into the blood-stream through the walls of the stomach and the intestines. It does not

: require digestion. It circulates throughout the body.

Detoxification : Alcohol is a drug that must be changed into a non-harmful substance. This vital function called detoxification is performed by the liver. The liver changes alcohol at the rate of one ounce per hour. Nothing will speed up this rate. When alcohol consumption/ exceeds this rate, the alcohol overload continues to circulate impairing brain centres, intoxication results.

Some Facts : Alcohol has no nutrients.

It is not a stimulatnt as many people think. It is a depressant and slowsdown the activity of the brain.

Alcohol enters the blood stream faster and quicker if:

(i) the person drinks rapidly or 'gulps'.

(ii) alcohol is mixed with soda instead of water.

(iii) alcohol is drunk on an empty stomach.

Combining alcohol with common medicines will lead to adverse effects.

: Addiction to alcohol affects badly
-physical and mental health
-occupation
-income
-family
-society

Drinking and driving is dangerous.

Hangover : The sick feeling (headache, upset stomach, nausea, unusual thirst) after drinking:
-Drinking black coffee or buttermilk.
-Pouring cold water on one's head
-Taking raw eggs.
-Rubbing lemon on one's head etc.,

will not overcome hangover. Only passage of time and rest will give relief.

Varnish, paint, paint remover etc., contain Methyl alcohol. It is poisonous and its consumption will lead to blindness and death also.

Black outs : The addict walks, talks and does many things when he is drinking.

: Later he forgets all that he did under the influence of alcohol.

Immediate effects of drinking. : Removal of worry or tension -Exhilaration- Loss of inhibitions - Emotional depression -Quarrelsome - argumentative -Inco-ordination, confusion -Weeping -or Giggly -Drowsy - Loss of consciousness.

Tolerance : The inexperienced drinker receivesa a more powerful reaction to a given amount of alcohol than does the experienced drinker. This process of adapting, gradually to the presence of alcohol is called "developed tolerance".

Withdrawal : The addict experiances symptoms like fits, convulsions etc., when he suddenly stops taking alcohol.

Denial : When a person takes alcohol excessively several problems arise (There are clearly visible to others). Yet, the person continues to say that he has no problem at all. This is called denial.

Why? : Protect themselves from the feeling Of hurmt, sad or guilty and also to continue with drinking.

Forms : (i) Simple denial

(ii) Blaming others

(iii) Minimising

(iv) Rationalising

(v) Diverting

(vi) Initiating fights and quarrels (becoming aggressive and hostile).

Physical and Psychological dependence is addiction.

Addiction is not moral weakness.

Addiction is not lack of will power.

Addiction is not a crime

Addiction is not a sin.

ADDICTION IS A DISEASE

And it requires medical and psychological treatment. Abstinence is the only method to control addiction. Treatment will help in controlling addiction.

The dimsease of 'addiction' goes through 3 phases:

1. Early Phase : increased tolerance
pre-occupation

Avoids any talk about alcohol

Blackouts.

2. Middle Phase	: loses control over quantity, time and place.
	keeps on giving reasons for drinking.
	Grandiose behaviour.
	Stops for some days to prove he has control but goes back to excessive drinking.
	changes his drink, place of drinking, time.
3. Chronic Phase	: keeps stock.
	steals, lies, borrows or goes to any extent to buy alcohol.
	drinks continuously without caring for any one or anything.
	experiences withdrawal symptoms like fits, convulsions etc., when he suddenly stops taking alcohol.

Regular excessive use of alcohol affects stomach, intestines, Brain, Spinalcord, Liver, Pancreas, Lungs, Skin, Heart, all parts of the body.

Community and family could help in early identifications of the disease. Treatment becomes easier if help is sought in the early phase.

-Addiction is a disease which affects both the addict and his family.

-The addict's family takes on various roles to cope with the situation -roles like protector, controller, blamer, etc., and ends up deeply affected and emotionally broken.

-Preaching, punishing, bribing, threatening, asking for promises, emotional appeals, etc., will not work.

-Before the disease gets worse, the addict and the family should go for treatment.

-The family members of the addict need understanding and help. During treatment, they get emotional help and guidance. As a result, they are able to manage their lives better and support the addict in his recovery.

9. Evaluation : By asking questions.

In respect of educational aids the following were available in the Department:

1. A video film on drinking and driving (2 minutes duration)
2. A video film on the successful experiences of an ex-alcoholic on treatment (particular part -3 minutes duration).
3. Poster designs.
4. Development of Transperancies

It was conceived that the content of the training could

better be woven in a story as close to the real life situation in slums as possible and initiate participation and discussions on the subject matter and give the message along with the story. For this transperancies were developed. Script for developing the transperancies how the messages are woven in a story are given below.

As most participants are semi or illiterate and over school age formal learning methods were not used. Stories can be a medium for learning and information can be communicated in way that is relevant to the participants life.

ALCOHOL & HEALTH

Intemperance in the use of alcohol creates many problems in modern society. These problems may be divided into 3 categories - psychologic, medical & sociologic

The main psychologic problem is why a person drinks excessively, often with full knowledge that such action will result in physical injury to himself and irreparable harm to his family.

The medical problem embraces all aspects of alcoholic habituation as well as the diseases which result from overindulgence from alcohol

The sociologic problem comprises the effects of sustained inebriety on the family and community.

The various problems caused by excessive drinking cannot be seperated from one another

It requires little projection of the imagination to conceive of the havoc wrought by alcohol in terms of decreased productivity, accidents, crime, mental and physical disease and disruption of family life.

(In 1971 in the USA an estimated 7 million men and women - 7% of the adult population manifested the behavior of alcohol abuse and alcoholism)

Gastro Intestinal Tract - morning nausea and vomiting
- gastritis
- peptic ulcer
- Mallory Weiss Syndrome (upper GT bleeding)
- alcobolic hepatitis
- cirrhosis

- alcohol intoxication - drunkeness, coma, excitement (pathologic intoxication)

ALCOHOL & HEALTH

I Considering the medical aspect:-

Ethyl alcohol :- It affects the various systems of the body as follows.

1. Gastro Intestinal Tract - High concentrations (more than 15%) produce irritation of the mucous membrane. Conc above 20% reduces enzymetic action of gastric and intestinal juices. This results in - morning sickness + vomiting, gastritis, peptic ulcer bleeding from the G.I.T.

2. Central Nervous System - Depresses the CNS in descending order. It removes inhibition, producing mood swings and uncontrolled emotional outbursts. They do silly and harmless antics, but can become vicious, and antisocial or reckless. Alcohol is incriminated in one out of five crimes of violences. Blood alcohol concentration of more than 80mg % greatly increases the risk of driving accidents.

The individuals

- Alcohol reduces visual security and interferes with muscular coordination - hence even moderate drinking is considered dangerous to public and individual safety - more so if the individual also takes other depressants like sedatives, tranquilizers or analgesics. - With increasing quantities the individual loses all,

Sense of Proportion - there is difficulty in speech, unsteadiness of gait and complete loss of self control are likely to follow

- very large quantities can cause unconsciousness
- Death occurs due to depression of vital medullary centres, mainly the respiratory centre

Some of the CNS effects are probably due to substances (ethyl acetate, isoamyl alcohol and butanol) other than ethynol present in these beverages.

- In epileptics, alcohol may cause convulsions

3. Cardio Vascular System - Habitual heavy spirit drinking over many years causes direct injury to the heart muscle causing "alcoholic myocardiopathy".

- Even a small amount of alcohol has been shown to depress the myocardial function in patients with coronary or valvular heart disease - hence prescription of alchol bo these patients as a "tonic" or "coronary dilator" is irrational and unwise

4. Liver - alcohol produces a "fatty liver", ultimately developing into cirhosis of the liver due to - i) stimulation of synthesis of fatty acids by liver ii) mobilisation of fat from periferal tissues iii) diminished food intake and deficiency of certain vitamins due to gastritis

5. Has a variable effect on the metabolism of drugs due to effect on the microsomel enzyme system

6. Has an erroneous reputation as a sexual stimulant. As Shakespeare quoted in 'Macbeth'; "Lechery, Sir, it provoketh and unprovoketh; it provoketh the desire but it taketh away the performance"

7. May produce prostatic congestion resulting in acute urinary retention

8. Large doses damage muscle, causing alcoholic myopathy

9. Chronic alcoholics suffer from various dietary deficiencies

- Blood alcohol concentration more than 80 mg% greatly increases the risk of driving accidents

10. Chronic alcoholism - repeated ingestion of alcohol can lead to addiction. In addicts, the normal feeling of well being depends on the continuous availability of the drug molecules ~~xxxxxxxxx~~ in the body fluids and tissues, and there is such an intense craving that the desire to drink remains the only interest in life. Sudden withdrawal of alcohol may lead to delirium tremens. In addition the alcohol addict is liable to other neuropsychiatric syndromes e.g. Korsakoffs psychosis, hallucinosis, suicidal tendencies, and Wernickes enceplalopathy. Generally there are also nutritional deficiencies e.g. polymeuritis, anaemia, edema.

Delirium tremens - restlessness, insomnia, tremors, hallucinations, delirium and even convulsions ("Rum Fits")

II

Methyl alcohol - poisoning usually results from ingestion of methylated spirits or adulterated wines

Symptoms - (due to CNS depression and acidosis)

- headache, ventigo, nausea, severe abdominal pain, dyspnoea, restlessness
- coma can develop very rapidly, followed by death
- death usually preceded by blindness
- However total blindness could occur with as little as 15 ml of methyl alcohol, while 70-100 ml is fatal.

A CLERGYMAN ASKS ABOUT A.A.

Many clergyman are already familiar with the Fellowship of Alcoholics Anonymous and withthe programme of Twelve Suggested Steps for recovery from alcoholism. They know A.A. as a nonsectarian, nondenominational ally in their own efforts to help problem drinkers. They know that religious leaders of major faiths have endorsed the AA program and that clergyman have themselves found in AA the answers to personal drinking problems.

Thousands now sober in AA owe their personal recoveries to spiritual advisors who directed them to a local AA group or who describes the recovery program from the pulpit or in writings. Esperience indicates, however, that some clergyman still have only fragmentary information about AA. Others are totally unfamiliar with the recovery program and a few appear to have erroneous concepts of the Fellowship and how it functions.

The purpose of this pamphlet, which reproduces questions about AA that are frequently asked by clergymanm is twofold. First, the Society wishes to record its debt to the many members of the clergy who have been and who continue to be so understanding and so helpful. Second, it is hoped that the material on the following pages will provide a useful introduction to AA for those clergyman who have not yet had occasion to become familiar with the Fellowship.

Finally, it is suggested that this pamphlet may also be helpful to AA members by helping them interpret to interested clergyman the Fellowship's unique accumulation of personal experience in the recovery of alcoholics.

Historical Note

What was later to become known as the Fellowship of Alcoholic Anonymous came into being in Akron, Ohio in 1935. It was founded by two men publicly identified only as Bill W., a former New York

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stock broker, and Dr.Bob S., an Akron Surgeon. Both had long histories of irresponsible drinking and had been regarded as 'hopeless' alcoholics.

In the fall of 1934 Bill., hospitalised for alcoholism, experienced a sudden spiritual 'awakening' that seemed to free him of the desire to drink. He tried to persuade other alcoholics that they could experience the same transformation, but none recovered.

The following spring, in Akron, after the collapse of a business venture, Bill was seriously tempted to drink again. Fearful of the inevitable consequences of taking 'the first drink' Bill recalled that he had had no desire for liquor during thepreceding months while he had been working with alcoholics in New York. In desperation, he sought a similar contact in Akron. A series of telephone calls, of which the first was to an understanding and cooperative clergyman, led to Dr.Bob. The latter impressed by Bill's recovery story and by the opportunity to share his own problem with an admitted alcoholic,achieves sobriety shortly thereafter.

More important, the two men discovered that their own sobriety was strenghened when they offered to share it with others stressing their own practical experience as recovered alcoholics . By the fall of 1935 a small group of sober alcoholics was meeting regularly in Akron.

Bill returned to the East where a number of other groups soon were formed. Dr.Bob, remaining in Akron, continued to be a bulwark of the new movement until his death in 1950.

The young society remained nameless until 1939 when the book 'alcoholics anonymous' recorded the recovery experience of about 100 members, most of them in Akron, Cleveland, New York and Philadelphia. Rapid growth began in the Nineteen-forties when the recovery programme first attracted widespread attention in the United States and Canada snd in a few countries overseas. An international service office was established in New York city in this period to handle the growing volume of inquiries about the recovery programme and to assist the new groups that were forming daily.

Today the movement has an estimated 4,00,000 members a majority of them are affiliated with over 14,000 local groups in

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more than 90 countries around the world. It is believed that women comprise at least one-fourth of the membership.

1. What is Alcoholics Anonymous?

Perhaps the best brief description of AA is contained in the two paragraphs definition that is read at many group meetings:

'Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other 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; we are self-supporting through our own contributions. AA is not allied with any sect, denomination, politics, organisation, or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety'.

2. Why should a clergyman be interested in AA?

Because AA members may be able to help a clergyman to help another alcoholic and because many alcoholics look to their clergyman for guidance both before and after becoming interested in AA.

3. How can AA help?

AA can help in only one way, by making available to the clergyman the practical experience of alcoholics who have learned to live without alcohol in any form. AA cannot usually help in situations where an alcoholic does not want help or feels that he can stop drinking without outside help. The best a clergyman can do in such cases is to let the alcoholic know that help is available when the alcoholic is ready to admit that he needs and wants it.

Many clergyamn ask AA members to meet with alcoholics to describe the AA recovery program.

4. How do alcoholics attain sobriety in AA?

AA members follow to the best of their ability a program

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of Twelve suggested Steps. In these steps the first members recorded the principles and practices through which they had attained sobriety. The Steps, which include elements found in the spiritual teaching of many faiths, are suggested only; they are not mandatory.Their acceptance by alcoholics is undoubtedly due to the fact that they are not theoretical or dogmatic in tone; they simply state the actual experience of men and women who have been able to solve their own problem of alcoholism.

Members are also enccuraged to attend meetings, at which they can share their experience with each other and with newcomers, and to study the AA program as it is described and interpreted in AA literature.

5. What are the twelve suggested steps of AA?

These are the steps through which an estimated 400,000 men and women have achieved sobriety in the fellowship of Alcoholics Anonymous:

1. We admitted we were powerless over alcohol that our lives had become unmanageable.
2. Came to believe that a Power grreaterthan ourselves could restore us to sanity
3. Made a decision to turnour will and our lvies over to the care of God, as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to havd God remove all these defects of character.
7. Humble asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our sonscious sontact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

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12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

6. Is AA a Temperance Society?

No, The Fellowship takes no position on the so-called temperance question. Collectively, its members neither 'approve' nor disapprove the use of alcohol by others. They have simply learned from experience that theycannot handle alcohol themselves. Recognising this fact, they concentrate on staying sober themselves and on helping other alcoholism who express interest in the AA recovery program. (As individuals, not speaking for the Fellowship as a whole, members are, ofcourse free to express personal view points on the temperance question).

7. Is AA a Religious Society?

No. AA is not a religious society or movement in the denominational sense although the recovery program includes suggestions that reflect the insights of many spiritual leaders. AA membership includes men and women of a variety of faiths, some who had no formal faith where they first turned to the Fellowship and some who continue to profess not to have any.

Members frequently describe AA as a 'spiritual' program. They do not mean that it is in anyway sectarian or denominational.

8. Is AA an Evangelical Movement?

No, not in any sense of the term. The Fellowship does not actively recruit adherents to a formal body of beliefs and the 'message' which it promulgates is of direct interest only to those concerned with the problem of alcoholism.

9. Does AA regard alcoholism as a sin?

As aFellowship, AA is committed to no theological concept of alcoholism. AA members may be said to be more concerned with coping with the problem of alcoholism than defining it. Within theSociety, there is, ofcourse, complete freedom for the individual to express his own view points on this question

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Most members regard alcoholism as an illness that cannot be cured but can be arrested by alcoholics who honestly attempt to practice the Twelve Suggested Steps in all their affairs.

10. What part do meetings play in the AA program?

AA meetings evolved naturally out of the early members' desire to share their experience and problems with each other and with new comers who sought a path to sobriety.

In time two basic types of meetings developed: 'Open' meetings for alcoholics and (in some areas) anyone interested in the problem of alcoholism, and 'closed' meetings for alcoholics only.

A typical program at an open meeting will have a chairman, or leader, and two or three speakers who review their own experience as 'practicing' alcoholics and who may describe what their AA sobriety has meant to them. Simple refreshments and coffee are usually served after the programmed part of the meeting and most members linger for a period of informal visiting.

Non-alcoholics attending an AA meeting for the first time are often surprised to note the gaiety and levity with which members describe their drinking experience. Some personal stories may be recounted in rather informal language, and there may be a distinctly non religious tone to an occasional talk. Others may be characterised by impressive expressions of spirituality and personal religious beliefs.

The important thing to remember is that each speaker speaks only for himself and not for AA as a movement. What all AA speakers have in common, however, is the desire to strengthen their own sobriety by sharing it with others.

Most members believe that regular attendance at meetings is essential to the maintenance of sobriety. New comers are encouraged to attend one or more meetings a week.

Closed meetings, for alcoholics only, give members an opportunity to share their experience more intimately and perhaps give special help and encouragement to members who are having difficulty adjusting to a life without alcohol.

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11. Are clergyman welcome at AA meetings?

Clergymen are most welcome at AA public meetings and (in come areas) at 'open' meetings. Local groups will gladly advise on the local custom. 'Closed' meetings are traditionally limited to alcoholics.

12. Does AA have a formal creed?

No. AA members are not asked to accept any formal creed or statement of beliefs beyond the admission that they have a drinking problem and want help.
Members are free to interpret the AA recovery program, as expressed in the Twelve Suggested Steps, in any manner they choose.
The unifying belief of the membership might be said to be the faith that a recovered alcoholic, by sharing his or her experience, can be uniquely effective in helping other problem drinkers. AA members do not believe that they have the only answer to the complex problem of alcoholism, but most would probably agree that the answer they have found is the only one that seems to work for them.

13. Does AA have basic literature?

There are four basic texts describing the AA program of recovery from alcoholism and the international Fellowship based on this program:

1. "Alcoholics Anonymous", also known as "The Big Book" describes the principles through which the first members achieved sobriety and contains personal histories of 36 recovered alcoholics.
2. "Twelve Steps and Twelve Traditions" by Bill W., the surviving co-founder of the movement, consists of interpretive essays on the Steps for personal recovery and on the Traditions recommended to assure survival of AA groups.
3. "Alcoholics Anonymous comes of Age" by Bill W., is an informal history of the Society's first two decades.
4. "The AA Way of Life" by Bill W., is a collection of meditative selections by AA's co-founder.

14. Do AA members recognise the authority of a supreme being?

When an alcoholic turns to AA for help, he is not asked about his personal religious beliefs. He is asked only:

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'Do you want to stop drinking?? An affirmative answer to this question is the only requirement for membership

Reliance upon a Higher Power is, however, central to the success of most men. and women who have achieved sobriety in AA. To many members, this Higher Power is a personal God, to whom they turn for help in achieving and maintaining sobriety.

Early in the development of AA it was recognised that many alcoholics are not prepared to accept the concept of a personal Deity when they come to the Fellowship for help.

Accordingly, the first members told these newcomers, in effect: 'We have learned from experience that we need the help of a Power greater than ourselves if we are to stay sober- We believe all men, if they are honest, will recognise their lack of power to solve certain problems on their own. We know, for example that when we were drinking we had become powerless over alcohol, and that we relied upon it to solve our problems. We suggest that you find a substitute for this destructive power, alcohol and turn to a Higher Power, regardless of the name by which you may identify that Power. We suggest that you turn your will and your life over to God, as you understand Him".

Some clergymen may be shocked to learn that an agnostic or atheist may join the Fellowship, or to hear anAA member say: 'I cant accept that 'God concept'; I put my faith in the AA group; that's my Higher Power and it keeps me sober'.

The answer, if any is required, is that the spiritual perceptions of most members deepen the longer they are in AA and attempt to follow the Twelve Suggested Steps. Many who have approached AA as professed agnostics or atheists have turned (or returned), with strong faith born of a personal experience of Divine guidance, to the established communions.

15. What do members mean by the 'Spiritual Side' of AA Program?.

Most members use this phrase to describe what they believe are the spiritual implications of the Twelve Suggested Steps. When they first come to AA, many alcoholics

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find that they are able to achieve sobriety even though they may have distinct reservations about the need to rely upon a personal Deity for help. These members apparently become sober sober through a combination of factors - admission that they are alcoholics and need help, the benefits of 'group therapy' the personal interest of older members etc.. that do not include surrender of personal will to a Higher Power.

Others find that sobriety is attained more easily and sustained more serenely if they re-orient their lives spiritually from the beginning, with speial reference to the spiritual 'disciples' suggested in the Twelve Steps. These members believe that the so-called 'spiritual side' of the AA program is the most helpful factor contributing to their rehabilitation.

16. What is meant by "the Group Conscience" in AA?

In matters affecting them as members of a local group, or of AA as a Fellowship, most of AA's believe that they can find their most reliable guidance in a wisdom that transcends personal or factional desires and judgements.

They believe that this wisdom materialises when they still their own voices, seek only what is good for AA and for still-suffering alcoholics, and rely upon the will of a Higher Power.

17. How is Prayer used in the AA Program?

There are two specific references to prayer in the Twleve Suggested Steps, as recorded by the founders of the movement.

The Seventh Step reads:
'(We) humble asked Him to remove our shortcomings".
And the Eleventh Step notes:

"(We) sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out".

At most AA meetings, all in attendance are invited to close the gathering by reciting the Lord's Prayer. Participation, ofcourse, is voluntary.

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Many members find spiritual strength in the following lines which in recent years have come to be known as 'the AA Prayer':

God grant me the serenity to accept the things
I cannot change,
The courage to change the things I can,
And the wisdom to know the difference".

This prayer is also recited at AA meetings in some areas.

18. Why do AA members insist on personal anonymity at the public level?

There are two reasons. One is quite practical; the other might be termed spiritual.

The practical reason is that many alcoholics might hesitate to approach AA for help if they did not have assurance that their anonymity would be protected.

The second reason has been expressed in the Twlefth of the Traditions which reflect AA's experience as a movement:

And finally, we of Alcoholics Anonymous believe that the principle of anonymity has an immense spiritual significance It reminds us that we are to place principles before personaliti ities; that we are actually to practice a genuine humility. This to the end that our great blessings may never spoil us; that we shall forever live in thankful contemplation of Him who ~~xxxix~~ presides over us all.

In actual practice, most of AA members do not mind if their friends learn that they have achieved sobriety within the Fellowship, Traditionally, all AA's are careful to respect fellow members! anonymity.

19. May Agnostics or Atheists become members of AA?

AA does not inquire into an alcoholic's religious beliefs- or lack of them - when he turns to the Fellowship for help.

Some alcoholics profess to be agnostics or atheists when they join AA. Although no formal inquiry has ever been made on

this subject, letters and reports reaching AA's General Service Office suggest that many of these members eventually affilitate with an establishment communion.

20. Does AA sponsor spiritual "Retreats"?

No. In some areas individuals who are members of AA may arrange retreats for alcoholics who wish to discuss or meditate on spiritual problems. It is however incorrect to identify or publicize these or similar ventures as AA affairs.

21. Are some AA groups limited to members of a single faith?

As a Fellowship, AA welcomes alcoholics of all faiths and whose who profess no faith. Locally, ofcourse, each AA group is autonomous in all matters not affecting the welfare of the society as a whole. Although no information on the religious composition of local groups has ever been sought by the General Service office, it is possible that all members of some some groups may be members of the same faith. Such groups would not would not be considered typical of "traditional" AA.,however

It is also understandable that, in groups where various faiths are represented, alcoholics who share the same communion may be drawn together outside AA for religious exercises distinctive to their faith.

So long as they do not jeopardize the integrity of the Twelve Steps recovery program, these groupings would not be considered to violate AA tradition. In this connection, it may be noted that AA groups are frequently formed for young people for 'beginners in AA' or for members who share common professional or business interests.

22. How is AA organised? Who runs it?

AA has always attempted to keep formal organisation to a minimum. There are no rules or regulations in the Fellowship no government in the usual sense of the term and no hierarchy of officers.

Traditionally, any two or more alcoholics meeting together for purposes of sobriety may consider themselves an AA group, provided that, as a group, they are self-supporting and have no outside affilitation.

Local groups generally select committees to handle essential group activities and services. Group representatives participate in the work of area committees which are concerned with with problems of interest to a number of groups. In North America, delegates from 80 odd AA areas meet annually to review the movement's world service activities and problems. Similar meetings are developing overseas.

No one 'runs' the movement and no individual speaks for the movement at any level of its service program

Custodial responsibility for supervising AA's movement wide service agencies has been entrusted by the groups to a General Service Board of Trustees which meets quarterly. The board is made up of AA members and non-alcoholic friends of the Fellowship.

In the words of A A's Second Tradition:
'For our group purpose there is but one ultimate authority a loving God as He may express Himself in our group conscience'

23. How are AA's activities and service financed?

AA is entirely self-supporting. It is a well established AA. Tradition that funds are not, under any circumstances, accepted from outside sources.

There are no dues or fees in AA Expenses of a local group (rent of meeting quarters, refreshments, literature etc.) are defrayed by voluntary contributions, usually are group meetings.

Most groups also contribute to the support of area.wide activities (sponsorship of services to alcoholics in prisons and hospitals, for example) and to the support of the movement's General Service Office in New York. This Office provides a number of services world-wide that local AA units are not in a position to offer. The General Service Office also derives a portion of its income from sale of Conference-approved literature to the groups. A substantial amount of literature is also distributed throughout the world without charge each year.

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Individual members may, if they wish, contribute directly to the support of AA's world services (Such an individual gift may not exceed $ 200 in any year).

24. What are the Twelve ~~xxxpx~~ Traditions' of AA?

Over the years, by a process of trial and error, the Fellowship learned that the survival of effective groups was linked closely to the observance of certain basic principles. These principles related to the conduct of a group's internal affairs, relations between groups and relations with the outside world.

These twelve principles, or Traditions, many of which reflect the spritiual orientation of the movement, were first reduced to writing as AA entered its second decade. Later, at the Fellowship's first international gethering in 1950, they were accepted by the members as 'guides' to assure the survival of the Society's service structure.

The Traditions are not formally binding on the groups. Members in some areas occasionally (and usually temporarily) deviate from them. But the overwhelming majority of AA groups throughout the world today ~~prfer~~ prefer to conduct their affairs and their relations with the general public in the traditional AA manner.

25. Does AA support Church Programs in the field of alcoholism?

Since its founding, AA has taken the position that the Fellowship has only one thing to offer; the personal experience of recovered alcoholics, to be shared freely with other men and women who seek release from the compulsion to drink.

Accordingly, although it cooperates with many agencies concerned with the problem of alcoholism, AA has traditionally avoided direct involvement in other programs in the field AA undertakes no formal research, for example, but makes information on its own recovery program available to all who seek it. AA sponsors no educational programs but answers many inquiries on AA from educators.

AA traditionally has never beenidentified or associated with private or tax-supported proposals, programs, propaganda or public fund raising in any area of alcoholism prevention or control.

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Individual members are, ofcourse, free to make their per - sonal experience as recovered alcoholics available wherever it can be useful, An increasing number of members are active in programs sponsored by non AA agencies. It cannot be stressed too strongly that they participate in these programs as individuals, not as members, or representatives, of Alcoholics Anonymous.

26. Are any clergymen members of AA?

Yes. Alcoholism is no respector of persons, whatever their position, profession or vocation in life may be. A number of alcoholic clergymen representing various faiths have achieved sobriety in AA and participate actively in the Fellowship's programe. There are a few groups composed exclusively of clergymen.

27. How may a clergyman cooperate effectively with AA?

There are several ways; by becoming familiar withAA's suggested recovery program through attendance at open meetings and through reading movement literature, by recognising the spiritual (though non denominational) aspects of this program, by calling on AA for help while appreciating the limitations of the work of AA members in the field of alcoholism, and by being patient with the human failings of individual members.

One clergymen who has worked with many problem drinkers believes that it is essential to be acquainted personally with active AA members in the community; thus when AA help is desired, an alcoholic can quickly be placed in the care of a member who will take special interest in the newcomer and help the latter to 'get a good start' toward recovery in AA. Another clergyman stresses the importance of counselling with the family of an alcoholic after the latter joins AA.

Because the sobriety of an AA member is strengthened when he has an opportunity to work with other alcoholics a clergyman indirectly helps AA whenever he calls upon a member to share that sobriety with another alcoholic.

28. How may an interested clergyman establish contact with AA?

In many areas an AA listing appears in the local telephone directory. A call to the number listed will normally produce a prompt response to any inquiry. Doctors, law-enforcement officials, newspaper editors or reports and welfare officials may alsobe able to provide information on AA locally.

Literature on the AA program and specific directions for getting in touch with a local group may also be obtained by writing to the General Service Office of AA P O Box 459 Grand Central Post Office, New York N Y 10017. Both the General Service Office and local AA members will be happy to work with clergyman who may be interested in seeing new AA groups formed in their communities.

29. What can a clergyman tell an alcoholic who expresses interest in AA?

Clergyman who have worked closely with AA would undoubtedly agree that the following points deserve emphasis:

First, try to impress upon the alcoholic that AA can probably help him only if he is sincere in his desire to stop drinking. Going to AA simply to please his spiritual adviser his wife or his employer may not be adequate motivation to enable him to achieve sobriety in AA.

Second, urge the alcoholic to keep an open mind on AA if the recovery program does not appear to make sense to him the first time he is exposed to it. He may change his first impression of AA if he will continue to attend meetings over a reasonable period.

Third, stress that AA has just one primary purpose to help the problem drinker to attain and maintain sobriety through sharing the personal experience of recovered alcoholics.

Fourth, remind the alcoholic that AA membership literally embraces a cross section of society. The newcomer will meet all types of people in AA from all backgrounds and walks of life. Whatever their difference, whether the newcomer is attracted to all of them or not, let him remember that they share his problem - alcoholism and are doing something constructive to solve that problem.

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Fifth, assure the alcoholic that, in line with AA tradition . . . his personal anonymity will be respected and that his problem will not be disclosed outside the Fellowship without his consent.

Finally, the alcoholic should understand thatm according to the best available medical evidence, he can never hope to drink normally again. He has two alternatives; progressive deterioration if he continues to drink, or a new and promising way of life if he will stop using alcohol in any form. In AA he will find literally thousands of men and women who will help him make the transition to this new life by sharing their experience with him.

A Closing Note -

Although it is not a religious society, alcoholics Anonymous is deeply indebted to the clergymen of many faiths who have befriended the Fellowship since its founding more than a generation ago.

The heart of that friendship has been understanding and tolerance - understanding of AA's capacities and limitations as a Fellowship, tolerance of the failings of a society of fallible men and women whose spiritual aspirations are higher than their human abilities.

It would be unrealistic to assume that all AA members are spiritually inspired. Many are not committed to a formal body of religious doctrine, But all AA members - including those of no communion-can bear personal witness to the transforming power of faith, to the unlimited possibility of redeeming the human condition however lowly, through an infusion of human love, brotherly care and non human spiritual Power

As it has been so often inth the past AA hopes that it can in the future continue to be the helpful ally of all clergyman who share a concern for the condition of the alcoholic who would take the first step toward freedom from alcohol.

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A study on Drug Addiction & Alcoholism and Treatment facilities available in Bangalore

Introduction:

Addiction is a State of periodic or chronic intoxication produced by the repeated consumption of a drug and involves tolerence, psychological dependence, physical dependence and an overwhelming compulsion to continue using the drug with detrimental effects. Addiction not only affects the life of the individual but also those of the family members to a great extent. Financial support as the bread winners role losses its meaning and the family is subjected to financial stress. It also causes disturbances in the general family harmony, marital relationship and Parent-child relationship. An alcoholic is inadequate in the care of children and inconsistent in his dealings with them, which serves as a negative role model. Thus the general family harmony, marital life and the childrens mental health face great risk.

In this study I would like to discuss.

~~(a) why do people take drugs~~
(a) what is a drug
(b) classification of drugs (c) why do people take drugs
(D) Pattern of Drug use in Bangalore (E) How to identify an addict
(F) Problems associated with addiction
(G) Types of Treatment (H) ~~Legal aspect, Rehabilitation~~ Prevention is better than cure.
(I) Field study with this regard.

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A. What is a Drug:

A drug is any substance, other than food, that by its chemical nature alters the structure and functioning of a living organism, alters mood personality or behaviour of an individual.

B. Classification of Drugs: Common way of classification.

1. Legal drugs :- alcohol, tobacco, coffee, tea.
2. Illicit drugs :- Cannabis [Marijuana, Bhang, Ganja, Hashish, gran, pot]
   Heroin [Brown Sugar, smack]
   Cocaine [coke, crack, snow]
   → → LSD [Lysergic acid Diethylamide]

Various forms of medication [aspirin ; pain relievers
dexamphetamines : Stimulants, Sleepaids

C. Why do people take drugs:

1. Experimentation or curiosity or adventure
2. Peer pressure - friends pressing to try
3. Search for an identity
4. Escape from reality and demanding situations
5. Rebellion, protest against social values.
6. Family disharmony [increasing family instability, poor family inter-relationship and communication, lack of parental Supervision and guidance]
7. → Boredom, depression
8. Dependency after Medical use
9. Media influence
10. → Rock culture, films here? censorship

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11. Plenty of spare time with no creative activities.
12. Financial :- Too much of money
13. Social occasions : celebrations, parties, picnics, tours
14. Easily available.

D. Pattern of Drug Use in Bangalore :- According to the study conducted by Health ministry in 1987.

52% of male students and quarter of female students had tried alcohol at least once.

a. Introduction to drugs by friends 66.3% - 97.30%.

b. Reasons for Drug use :-

1. Group activity	63.2 %.
2. Solve problems	51.4 %.
3. Forget worries	49.7 %.
4. Cure for common ailments	43.5 %.
5. For Fun	7.8 %.

c. Reasons for increased consumption :

Company of friends	63.5 %.
More money available	43.2 %.
More stress	42.4 %.
Easy availability of drugs	16.1 %.

E. How to identify an addict :

1. Uncharacteristic behaviour - Silent student becoming very vocal or an extrovert student remaining quiet.
2. Rapid mood change - happy one moment and sad be next.
3. Change in relationships - interpersonal relationship
4. Fall in Scholastic performance

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5. change in circle of friends
6. Absentism and truancy truancy?
7. Physical symptoms :- a) drugged look b) ill kempt
c) Sunken or blood shot eyes d) Dilated or constricted pupils
e) Dry tounge f) increase in sweating g) Change in speech- Slow, slurred, disjointed h) Tremors.

In addition parents may note: irregular night hours, increased demand for pocket money, change in friends.

F: Problems associated with addiction:

The health damages of a regular drug use take numbers of years to manifest. This time lag of cause and effect makes it very difficult for users to realise the potential danger. More over, much of the damage is subclinical not visible or dysfunctional. These intangible and non-manifest minimal losses, change in personality, increasing irritability and difficulty in functioning are not readily noticed.

Some common damages of frequently used drugs are:

1. Tobacco - a) Smoking - respiratory problems, cardiac disease and cancer.
b) chewing - mouth cancer and overall systemic damage, ulcers, gastritis, nutritional deficiencies.
2. Alcohol - brain damage, and liver damage, gastritis, nutritional deficiency, overall systemic damage.
3. Cannabis - brain damage, some amount of liver damage and drug induced psychosis of short duration.
4. Heroin - brain damage, associated depressive syndrome - suicides, decreased immunity.

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A drug user may confine his or her relationship to the circle of drug users and hence loses other friends. Quarrels in the family are frequent. Much money is expended on drugs with consequent decrease in buying power. Loss of job, income and property may result.

(iii) Types of Treatment:

1. Detoxification:- Various tranquilizers are given to help the addict to tide over the acute withdrawal symptoms

2. Drugs: Antabuse (disulfiram) is used in treating some alcoholics. The drug interferes with the metabolism of alcohol and produces acetaldehyde, which causes flushed face, headache, increased heart rate, nausea, vomiting and breathing difficulty. If the alcoholic person ingests alcohol while on the drug he or she will experience these symptoms. Thus deterring alcohol use.

3. Family therapy: Some changes (adjustments) in the rest of the family to give support to the problem person.

4. Group Therapy:- Group interaction, T.A with help of Therapist, Halfway home, Alcoholics anonymous.

5. Psychotherapy:- Individual psychotherapy & counselling

6. Aversion Therapy:- "Therapy bar" Antabuse.

7. Forced crisis programme in industry:- workers are forced to treatment if they are alcoholic. If has 80% success rate.

H. Prevention is Better than Cure:

(i) Peers, teachers and parents can play an effective role in preventing initiation or preventing experimentation from turning into regular use. Professional help can be sought only in cases of regular or dependent use. Even then counselling can be done by teachers and parents of peers who may not have the professional training. Activities can be co-ordinated between the parents and teachers utilising forum like Parent Teachers Association (PTA). For the student addict to overcome the psychological and social disabilities, the support of fellow students family and teaches is essential.

(ii) Rehabilitation: Rehabilitation is a crucial aspect in the recovery process because most successfully treated drug users never back due to lack of support. Families, friends, and the community at large, have a major role to play in providing meaningful occupation.

(iii) Tasks which could be undertaken by school authorities:-

1. The teachers could be given a brief period of training about the problem which will increase their awareness.
2. Students, who lag behind in their academic performance need to be monitored.
3. It could be ideal to interact with parents of students at regular intervals.
4. Keep a watch on the suspicious persons entering school/college premises.
5. In and around schools 'drug pushers' may be present. Keep a tab on them, inform police.
6. Identify 2-3 students in each class who could be volunteers to help persons seeking help.
7. Arrange regular talks, lectures, film shows to make the students aware of the problem.

Legal ~~aspect~~ issues:

NDPS ACT 1987 :- [Narcotic Drugs, Psychotropics Substance Act]. This Act brings such offences under the Act list of cognisable, non-bailable offences and liable to a minimum of 2 years imprisonment and a fine of 1 lakh rupees. The Act differentiates between "pushers" and "addict pushers". One would also be aware of the efforts by the Directorate of Revenue and other endorcement agencies in controlling supply of such drugs through the illicit market. It is a common belief, sincere and dedicated efforts in this direction in any country, like in India, can not have enough or satisfactory effect in figuring menace of drug use in the society.

Or Enforcement?

'I' FIELD STUDY:

1. ST. John Medical College Hospital B'lore:

Person met (a) Dr. Srinivas - Psychiatrist.
(b) Sheela - Social worker,
(c) Tania Machado? Psychologist.

At St. John Medical colley hospital mostly they treat the alcoholics the treatment given is detoxification, followed by counselling and group therapy. The Psychiatrist and the people involved in the process were happy about the success rate with regard to alcoholics, but they were not happy with regard to Drug addiction treatment since they didn't have Rehabilitation facilities.

Dr. Srivivas the Psychiatrist felt that Educating the vulnerable group and parents is must and the treatment is not complete ~~with the~~ without Rehabilitation.

Sheela the Social worker felt that Group therapy and family counselling are very important. Tania Machado stressed that ~~importance~~ creating awareness encouraging the peer groups, counselling and concentrating on Preventive measure are most essential. She is for Severe (capital punishment) for offenders (drug peddlers)

2. NIMHANS :-

Persons met : Dr. Jayashree Ramakrishnan [Health Educator]. At NIMHANS they treat both alcoholics as well as Drug Addicts. The treatment given is detoxification followed by counselling. She was not happy with the success rate, she also feels that the treatment is incomplete without Rehabilitation.

She feels creating awareness to student Community might backfire but her department is involved in taking films to create awareness to School children and industrial workers. NIMHANS Health education department is well equipped to train any group who is interested in working with alcoholics and drug addicts.

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3. CREST: [Centre for Research Education, Service and Training for Family life Promotion] 14, High Street, B'lore - 5.

Person met: Dr. Mascarenes
Dr. Paul Pereira
Mr. Vijayakumar
] They are involved in counselly & Guidance for Youth, Students and families

→ in the regard Smoking, alcoholism and drug addictions: They are also involved in the Natural family planning.

→ They undertake programme on :- Smoking, Alcohol, Drugs and family life Education Programme in colleges, High schools, Institutions, Industries, organisations. They also conduct aptitude testing for Students on Tuesday and Thursdays.

4. Helping Hand: [9/1 Museum Road, B'lore - 1] 10 AM - 12 Noon 4-7 P.M

Person met: Alice Saldana.

At helping hand they render voluntary Service to persons with any sort of Problems. They are having 17 volunteers, they are basically called as Listeners. They listen to the problems of the people, counsel render counselly Service and refer cases accordy to their problems. The volunteers are yearly once trained in counselly.

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5. Dr. M.J. Thomas [Psychiatrist Madurai]

Dr. M.J. Thomas clarifies Drug addicts as Anti Social personality and Social Personality. He feels Social personality can be treated but not Anti Social Personality. His treatment involves one week physical treatment i.e detoxification and 1 year counselling is must and the patient should not be accessible to the drugs. He feels legal issues with regard drug pushers she must be tightened.

6. A Thiruvalluvar Saikthi :-

Person met : Fr. Hank IVN.

→ Athma Sakthi mean Christ every day & Ministry

At Athma Sakthi treatment involves heavy physical workouts (body work) such as bioenergetics, Footbal they have lot of group activity, Fitness is a common affair. Duration of treatment is between 1-3 years and he says they dont have relapse cases at all. Mostly they take only Mentally ill people. Minimum monthly expense per patient is Rs 2000/- and they give concessions for the deserving cases. They have a regular → routine of heavy body work (there is no physical exercise).

(7) Halfway home :- [47, Bibby Road, B'lor-5.]

Halfway home is a place for people who are getting well from mental illness. They involve the patients in group activity like dance, music, art, current affairs discussion, cooking, shopping, praying, games, aerobics and Yoga. Each patient has to pay a fee of Rs 950/- per month.

(8) Maharishi Yogi Meditation centre :-

Here they firmly believe that through meditation a person will become good and he will himself stop from drugs/alcohol and other anti Social behaviour and work for peace. Here they show some video films about Brain cells, work of brain and how meditation helps in concentration. Here they instruct meditation for Drug addicts and ask them to do twice a day in morning ~~day 5am rise~~ and evening. According to them if the addict does the meditation regularly he will automatically stop from taking drugs or consuming alcohol. Accordg to them success rate is cent percent if the person regularly does meditation.

Conclusion :-

Different types of treatment methods are suitable for different individuals and the outcome of treatment largely depends on the individuals own motivation, treatment provided, the after care and the social circumstances which operate following treatment. Rehabilitation will have to be a concerted effort on part of the person, treating team and the social network of friends, teachers and family members. It is important for the person to get a feeling of being "accepted" in the society but at the same time some watchful monitoring also becomes necessary to avoid apparently insignificant situations leading to relapse.

In our country the Legal system should enforce stricter laws to deal with drug pushers/dealers so that we can have a check on easy availability of drugs in the market. In the present system it is a well known fact that all sort of drugs are easily available in the market and the pathetic state is they are available next door to any treatment or rehabilitation centres. I would like to close the study with two proverbs for this problem.

"Prevention is better than cure"

"Where there is will there is way"

Reference : 1. Drug MISUSE [DM 3] - Issued by the Department of Health & Social Security and the welsh office - UK.

2. A paper on Abuse Prevention - Dr. Jayachandra Ramakrishna Professor (H.O.D) NIMHANS.

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 does the spouse, or even more. Adults can choose their spouses; so also they have the option to leave 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 drags along. He does not have the same spontaneity which the other kids have. But nobody really notices it. Even if they do, they probably do not understand.

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; mischievious, playful,

doing work for approval or for reward, but always doing as little as necessary. The most important fact is that he is always care free.

In contrast, the child of an alcoholic is not a care free 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 sometimes or the other. But he is powerless to do anything about it.

Children in families with alcoholism syndrome are generally ignored because all attention is directed either towards the alcoholic parent or towards his alcoholism. The self-centered, 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. 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 adjustmental problems.

In addition to emotional and adjustmental problems, severe medical disorders have also been associated with the children of alcoholics - Fetal Alcohol Syndrome, Hyper Active 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 Hyper Active Child Syndrome' becomes noticeable when the child is about three years old. It is characterised by inattention, lack of concentration, impulsivity and hyper active behaviour. These children can easily be distracted and as a result they experience all sorts of 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 yard stick to define any situation.

The alcoholic father is sometimes very loving and warm. He displays everything that 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. These are the moments when he is drunk. He does not come at all; the child waits and is worried. When he comes home, he picks up a big fight, 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, he is not able to find anything to replace it with. He has not learnt any other method to handle 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 the intention to do good. 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 its meaning.

If they are confronted with 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 shapes - denial of problems leads to denial of the feelings produced by those problems.

Honesty, when applied in traumatic situations, will often cause discomfort and uproar. Therefore these children learn to

minimise , discount and rationalise for fear of the consequences, which are likely to follow if they speak the truth. Often when the child speaks the truth, he is told that what he sees and reports are 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. It 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 are normally negative feed backs and he internalises these messages. Sometimes the child gets double messages, one contradicting the other. He does not know which part is true ; so he sometimes 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. The child is unable to believe

that 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 focused on the child. It is always focused 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 the inescapability of the 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 simulatenously it craves for it. Beneath the mask of self control, is a lonely, frightened child, hungry for caring, 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 assumed by them voluntarily.

*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 Placater 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.

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* 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'.

Responsible child

The responsible child generally takes over the responsibility of the parents. This child provides stability to 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 an 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 and self-reliant, 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 child. But the truth of the matter is, they 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 off his vomits, changing his soiled clothing, or carrying him to the bed.

Deprived of the nuturing, 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 occuring in his life. Adjusters do not attempt to change, prevent or alleviate any situation. They simply adjust - that is, do what they are being told. They detach themselves emotionally, physically and socially as much as possible.

For example, the child would have been promised new clothes for a function. 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.

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 a 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. They cannot assert themselves even while being aware of being manipulated. They, therefore, get victimised in many ways at home, in their place of work and in other social inter-actions.

The Placating child:

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

This child is always busy taking care of everyone else's emotional needs. It assists its 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 scared, 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 -

(1) Don't Talk
(2) Don't Trust
(3) 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.

The next day was Meena's English Exams. 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 the drunken father.

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 the needs of her father.

Her eyes were red, swollen and droopy. When she entered the school, her most intimate 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 have a good sleep'.

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 will.

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 down her family.

'I will not talk or disclose. 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 see 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.

Rekha's father had all along made so 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!!

But none of these things ever happen - All only Lies. The declaration next morning will always be 'I will do it not now; but later!'.

The 'later' never comes. Therefore, the message to this child is, 'forget it - do not believe any one - do not trust anybody!'.

Don't Feel:

These children do not have a model for the identification of 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, not to talk about the problems or the consequences that it causes. Direct reprimands for expression of feelings is also common.

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

They learn that expression of feelings will be met with disapproval, hostility or rejection. In order to avoid what they can only view as punishment, they learn to suppress their 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.

- 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 anesthetising effect of alcohol.

- These children are victims struggling desperately to get away from their hurt and confusion. These innocent victims need enormous amount of understanding, comfort, care, information and above all, supportive psychological treatment.

DRINKING PROBLEMS

DEFINITIONS

(1) "Must stop but can't".

(2) (a) excess for that community;
(b) causing harmful effects - physical, psychological, social.

(3) (a) Alcohol dependency syndrome - physical condition with morning shakes and/or morning vomiting, eased with drink. Hallucinations, delirium tremens, possibly fits.

(b) Alcohol-related disabilities

(i) physical - many, affecting all physical systems. Effects on brain - see separate sheet, include alcoholic blackouts, memory loss, Wernicke Korsakoff syndromes, dementia;

(ii) psychological - preoccupation with drink, problem-solving with drink, suicide 50 times expected;

(iii) social - family, work, home accidents, traffic accidents, police problems.

CAUSES - multifactorial, including:-

(1) Overall increased alcohol consumption in a country is associated with increase in alcohol associated problems.

(2) Increase in total consumed is related to increase in disposable income.

(3) Community controls - licencing laws, social attitudes, e.g. young people.

(4) Life-style, e.g. job (barmen, services, salesmen, doctors), young single men, divorced, separated and unmarried older men.

(5) Parental example - extremes of parental attitude to drink associated with problem drinking in children.

(6) Lack of support from family, community agencies. Loss of work and relationships, i.e. no reason to stop drinking.

(7) Genetic - conflicting evidence.

(8) Personality - can affect any kind of personality.

DETECTION

Health staff are poor at this due to failure to enquire and also negative attitudes. General Practitioners detect less than one quarter. At least 20% of patients in Accident and Emergency Departments, General

Contd.....

Medical and Surgical Wards, have drink problems which are not recognised.

(1) High association with peptic ulcers, gastritis, anxiety and depression, accidents in the home and elsewhere, particular jobs - see above.

(2) History-taking - ask last drink, how many today and in the last week.

(3) Physical examination - breath, injected conjunctiva, heptomegaly, unexplained trauma or forgetfulness.

(4) Blood tests - macrocytosis (MCV > 94), raised SGOT and raised gamma glutamyl transpeptidase. Limited value.

(5) Questionnaires, e.g. CAGE, MAST.

SAFE DRINKING

No agreed safe limit. College of Psychiatrists recommend a maximum of eight units for men per day (four pints of beer or eight single spirits or one standard bottle of wine) and six units for women. Recent survey of workers with problem drinkers recommended a maximum for the male of six to seven units per day, female three units. One unit = 9G ethanol.

EFFECTS OF TREATMENT

Rand Report of 45 treatment centres with 2,000 clients found 70% improved with treatment. Follow-up of untreated controls found that 50% had improved.

Edwards & Orford compared intensive specialised and prolonged treatment with the effects of one or two counselling sessions with patient and spouse and found the outcome of each was the same.

Conclusion - no specific form or length of treatment was associated with success. Being in treatment appears to be the most important factor - presumably related to motivation for change. Counselling - need not be provided by a high powered specialist. Effective treatment can be provided by volunteers and primary care team members.

Measures are especially effective when the person is well motivated and there are helpful marriage and/or work factors. Agreement between management and unions that detection of drinking leads to threat of loss of job unless agrees treatment shown to be highly effective.

Contd.....

Controlled drinking - possible, i.e. abstinence not always necessary. See separate sheet on sensible drinking.

COMMUNITY RESPONSES TO ALCOHOL CONTROL

(1) Reduction of availability - production, distribution, price, promotion.

(2) Reduction of demand - information, norms, encouragement constraints already present in community.

(1) Proven Useful Methods

(a) increased price;
(b) increased minimum drinking age;
(c) increased probability of detection and punishment of drinking and driving.

(2) Possibly effective not proven

(a) education children and adults in effects of alcohol;
(b) education health professionals in physical, psychological and social effects.

(3) Evidence of effectiveness conflicting

(a) controls of production;
(b) reduction of distribution of alcohol;
(c) regulation of advertising;
(d) production of beers with reduced alcohol content.

Summary - need for national response, possibly with national co-ordinating group for alcoholism. The World Health Organisation is collecting information on effective community responses and is available for advice.

MH 2-14

Rs 1/-

What is Marijuana ?

Marijuana (Grass, Pot, Weed) is the common name for a crude drug made from the plant 'Cannabis Sativa'. The main mind altering (Psychoactive) ingredient in Marijuana is THC (delta-9-tetra-hydrocannabinol) but more than 400 other chemicals also are in the plant. The amount of THC in the marijuana determines how strong its effects will be. The strength of today's marijuana is as much as ten times greater than the marijuana used in the early 1970's. Hashish or hash, is made by taking the resin from the leaves and flowers of the marijuana plant and pressing it into cakes or slabs.

Effects of Marijuana :

Some immediate physical effects of marijuana include a faster heart beat and pulse rate, bloodshot eyes and a dry mouth and throat. Studies of marijuana's mental effects show that the drug can impair or reduce short term memory, alter sense of time, and reduce ability to do things which require concentration. Long term regular users of marijuana may become psychologically dependent. In addiction, when young people start using marijuana regularly, they often lose interest and are not motivated to do their school work. The drug can become the most important aspect of their lives. Research studies suggest that the use of marijuana during pregnancy may result in premature babies and in low birth weights. Studies suggest that it is likely that marijuana may cause cancer if used for a number of years.

Answers to our Drug Quiz

How well Did you Do ?

1. **TRUE :** Brown sugar is a crude form of heroin which is catching on very fast with the young people.
2. **TRUE AND FALSE :** Some times these pills and capsules are prescribed by medical doctors, but many times they are used to get a 'high'. They are called 'uppers' or 'downers' by the user.
3. **FALSE :** In all but few cases the drug being given to cancer patients to control nausea from chromotheraphy is a marijuana chemical called Delta-9-THC. Saying that the cancer patients use marijuana rather than THC is like saying that someone with a strep infection is using mould rather than penicillin.
4. **TRUE :** Infact hubble bubble can also be made out of a tube or pen and a container. Addicts who are used to hubble bubble carry it with them as handy device. Marijuana and Heroin are mostly used for hubble bubble.
5. **FALSE :** According to the National Institute of Health, chewing tabacco is a major factor in cancer of the tongue, gums and cheeks.
6. **TRUE :** a) Balls or cubes of hashish which is usually smoked in a joint or pot. b) Strip of Aluminium foil used for chasing Brown Sugar. c) Strips of paper used for chasing Brown Sugar. d) Chaser used for inhaling the smoke of the Brown Sugar with the help of lighted paper strips or tissue papers.

What is Cocaine ?

Cocaine is a drug extracted from the leaves of the coca plant which grows in South America. Cocaine appears in several different forms. Cocaine hydrochloride is the most available form of drug and is used medically as a local anesthetic. It is usually a fine white crystal-like powder although at times it comes in larger pieces which on the 'Street' are called 'rocks'. Cocaine is usually snuffed or snorted [illegible] nose, although some users inject it.

Effects of Cocaine :

Some immediate effects include dilated pupils and increases blood pressure, heart rate breathing rate and body temperature. The user may have a sense of well being and feel more energetic or alert and less hungry. People who use high doses of cocaine over a long period of time may become paranoid. People can become dependent on cocaine. Though few people realize it, over dose deaths can occur when the drug is injected smoked or snorted.

What is L.S.D. ? (lysergic acid diethyla[illegible])

L.S.D. is manufactured from lysergic acid and is one of the most potent mood-changing chemicals. It is odourless, colourless and tasteless. L.S.D. is sold on the street in tablets, capsules or occasionally in liquid form. It is usually taken by mouth but sometimes injected. Often it is added to absorbent paper such as blotter paper and divided into small decorated squares, with each square representing one dose.

Effects of L.S.D :

The physical effects include dilated pupils, higher body temperature, increases heart rate and blood pressure, sweating, loss of appetite, sleeplessness, dry mouth and tremors. The person's sense of time changes. The user feels of hearing colours and seeing sounds which can cause panic. Heavy users sometimes develop signs of organic brain damage.

What is Heroin ?

Heroin is made out of poppy plant. First it is collected by scraping the opium and made to gum opium, then opium is made to morphine by a chemical process and synthesized from morphine into Heroin. Pure heroin is a white powder with a bitter taste. Illicit Heroin may vary in color from white to dark brown because of impurities left from the manufacturing process or the presense of additives such as food colouring, cocoa or brown sugar. Brown Sugar which is mainly used by the teenagers contains only 10% of heroin. Recently a test made on Brown Sugar contained 50% of rat poison and other additives.

Effects of Heroin :

Euphoria, drowsiness, respiratory depression, constricted pupils and nausea.

Effects of Over Dose :

Slow and shallow breathing, clammy skin, convulsions, coma and possible death.

Withdrawl Syndrome :

Watery eyes, running nose, yawning, loss of appetite irritability, tremors chills, sweating cramps and nausea.

Drug Abuse Can Be Prevented

And Parents Can Help.

"It could not happen to one of m children", is a dangerous delusion parents but there is a lot you can do reduce risks and to protect your son daughter against pressure to use drugs.

a. Discuss with other parents what happening in the school and neigh bourhood.

b. Equip yourself with information abo drug abuse, particularly marijuan and heroin and effects of such abus

c. Co-operate with other parents in dr prevention.

If you are interested in your chil this information may help you.

The first drug does the damage

Produced in co-operation with

Asha Bhavan (Drug Rehabilitation Center)
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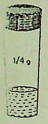
What do you know about Drugs?

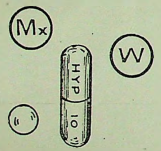
ake this true or false quiz to see how much you really know about kids and Drugs.

(See Answers Inside)



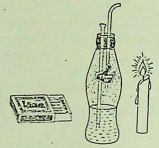
1. Children are discovering a new 'High' that can be dangerous : Brown Sugar.

2. Are these pills and capsules really prescribed by Medical Doctors.

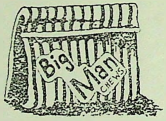


3. Marijuana is being used to treat cancer patients' nausea.

4. Are Papaya stems used to make Hubble Bubble.



5 Chewing tabacco won't hurt you.



6. Are these figures related while using drugs.

Covering up for Drugs :

Until you find drugs or drug paraphernalia you won't know any thing. It is possible of course, to detect the smell of alcohol or signs of being under the influence. But you may not be able to detect the use of pills or cannabis (pot) unless you find materials like dried leaves, the end of joint, rolling paper etc. Often teenagers use incense in a room to mark the smell of cannabis. Room deodorisers are often used for the same purpose. Some will admit to taking alcohol to cover signs of cannabis intoxication. If your teenager is using cannabis, his eyes are likely to be blood shot and his complexion pale.

Other Tell - Tale Signs

Depression; not going to school; has he dropped out of sports or other active pastimes?; Continual sniffles; red watering eyes; has his thinking become muddled; does he seem over active?; has he become impulsive?; A low tolerance of frustration; gets unusually upset if things don't go his way or right for him; does not immediately get what he wants.

3. Does he wear sun - glasses at odd times? This could be just a fad, or it could be to cover dilated pupils of the eyes because of cannabis, or constricted pupils from heroin use

4. Does he make unusual efforts to cover his arms?

5. Are you finding blood on his shirts?

6. Are the bed clothes being burnt through his falling asleep intoxicated?

If you observe any of this signs, It might be a good idea to search his room, belongings places around the house for Drugs and Drug Paraphernalia. Get to know more about his friends, where he goes and what he does. If you suspect anything don't blame him immediately. Take advice from people who know about Drugs.

The First Drug Does

The Damage

Just For Today - No Drugs

I Can't Do it Alone.....

.....But I Alone Can Do It.

Ask yourself the following Questions :

1. Has he suddenly become different to his usual way of behaving and relating to the family?

2. Have a closer look at his friends. Has he dropped long standing pals for strangers?

3. Has he lost weight.

4. Is he now comming home far later than usual.

5. From being reasonably active and capable at sport, study, work, has he changed to being indifferent or abandoned them?

6. Has he become vague, withdrawn, irritable, aggressive?

Ask yourself if Drugs are Involved and find out.

Some Important Indicators are :

1. Does he hang around with known drug users?

2. Are things vanishing from the home that could be sold?

MH 2-15

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

DEPARTMENT OF COMMUNITY HEALTH

GRITO - IFCU WORKSHOP

on

ALCOHOL and DRUG ABUSE

P R O G R A M M E

9.00am - 9.15am	Registration
9.15am - 10.30am	Presentation of Results of GRITO study (Magnitude and Factors relevant to urban situation)
10.30am - 10.45am	COFFEE BREAK
10.45am - 12.00pm	Group discussion - 5 Groups. 1) Factors related to Family & Peers 2) Socio-economic Factors. 3) Implications on Individual 4) Implications on Family 5) Implications on Community Facilitators: Dr. Tanya Machado Dr. R. Galgali Dr. Maya Abreu Mrs.Phyllis Farias Dr. Reynold Washington
12.00pm - 1.15pm	Presentation of Group discussion
1.15pm - 2.00pm	LUNCH
2.00pm - 3.15pm	Group Discussion on ACTIVITIES FOR DEMAND REDUCTION (Functionally homogenous groups)
3.15pm - 3.30pm	COFFEE
3.30pm - 4.30pm	: Plenary Session Chairperson: Dr. Dara S. Amar

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447 7/12/9x

CULTURE AND DRUG ABUSE IN ASIAN SETTING

The ubiquity of drug use is an established fact. The escalating large scale abuse of drugs however, is a contemporary phenomenon that has assumed menacing overtones. Understanding what constitutes use and abuse of drugs and the response of the society to drug taking behaviour cannot be divorced from the socio-cultural milieu in which such behaviour occurs. Similarly, any programme aimed at demand reduction should develop from within the cultural context. This philosophy has shaped the present study.

The major objectives of this study were to understand the historical social and cultural factors related to drug use and abuse in India, to monitor the trends in drug abuse, to determine the epidemiological and social cultural characteristics of drug addicts and to identify and evaluate the existing demand reduction programmes for prevention of drug abuse, rehabilitation of addicts and to develop modules for personnel involved in prevention and intervention.

Using a multidisciplinary approach, information was obtained from as varied and as diverse sources as possible. Techniques employed were a historical, sociocultural study, collation of existing information, interviews with addicts, analysis of case histories (medical records), interviews with key persons such as psychiatrists, counsellors, principals of schools and colleges, wardens of hostels, police, etc. House to house survey were also carried out in a village, slum and an urban area.

An ethnohistorical study reveals that India is an unique example of culturally sanctioned, yet with inbuiltsocial controls that limited and prevented misuse. But in the 1980s, social political and economic changes resulted in an upsurge of illicit drug trafficking, increase in drug abuse and drug related crimes in India. An overview of laws related to drug control reveal inadequacies in the law and its enforcement.

Case studies and interviews with addicts reveal that drugs are abused mostly by younger, male, single persons, either student or unemployed. Peer pressure is the major reason initiating youth to drugs and drop out rate from deaddiction programmes is high. The most abused drug in Bangalore is cannabis, but polydrug abuse is also common. Extensive contact with other drug users, lack of religious affiliation, inability to use leisure constructively and easy availability of drugs in Bangalore were the major sustaining factors in drug abuse.

Community surveys using open ended interview schedules yielded richdata ragarding community beliefs and practices. The drug users from rural areas were generally older, male, uneducated and employed. Use of drugs was in social gatherings, occasional, limited and was for socio religious reasons. In slums, drug users were younger, unemployed or in unskilled jobs and were given to poly drug abuse. In urban areas, students from affluent background were the main users. Thus drugs are used variously as social lubricants, as an escape from poverty, hardships and boredom and as a part of socioreligious activities. The psychiatrists interviewed in this study, treated on an average 10-15 addicts per year. Principals and teachers admitted drugs to be a problem but had not faced much of it in their colleges. A majority of police officers interviewed did not consider drug abuse as a priority for them, but opined that the police force is not sufficiently equipped to deal with this problem.

Both formal and informal methods of dealing with drug abuse exist in our culture. Most of the institutionalized formal methods use western models of treating addicts, with little or no attention to the sociocultural ethos. Coming to the issue of prevention of drug abuse, practically everyone emphasized the importance of family and peers in both drug use and its prevention. Awareness programmes, skills training, structured leisure activities, strict enforcement of laws and better rehabilitation and after care facilities are considered as essential.

Drug abuse is a multifactorial phenomenon with individuals using drugs in a variety of ways for a variety of reasons and in a varriety of contexts. Any intervention/prevention designed should be sensitive to this socio-cultural reality.

Organizing primary health care services to combat drug and alcohol abuse

A number of principles must be borne in mind when health services are being developed to deal with drug- and alcohol-related problems in the community:

- Medical science and technology are appropriate for treating individual diseases, but are not sufficient to reduce and prevent drug- and alcohol-related problems.
- Drug- and alcohol-related problems have to be dealt with through primary health care, with emphasis on decentralized care for the promotion of health and the prevention of disease, active participation of the family and community, use of non-specialized primary health care workers, and collaboration with personnel in other governmental and nongovernmental sectors.
- The whole health sector should be structured to support decentralization, through delegation of knowledge and skills to primary health care workers and to the people themselves, to promote health for all and general well-being.
- Mental health care and the skills to deal with drug- and alcohol-related problems should be essential components of primary health care, carried out in the course of everyday activities.
- Primary health care workers should be trained in simple but effective techniques to combat drug- and alcohol-related problems, including mobilizing community action, stimulating self-help groups, providing health education, and encouraging healthy life-styles. They should be trained in skills such as interviewing, counselling, maintaining social support, crisis intervention, and providing guidance about the use of leisure time.

Functions of primary health care services

The functions of the primary health care service in relation to drug and alcohol abuse can be considered within a framework of three levels of

prevention:

Primary prevention aims to avoid the appearance of new cases of drug and alcohol abuse, by reducing the consumption of drugs and alcohol through health promotion.

Secondary prevention attempts to detect cases early, and to treat them before serious complications cause disability.

Tertiary prevention aims to avoid further disabilities, and to reintegrate into society individuals who have been harmed by severe drug and alcohol problems.

The PHC worker will be involved at all of these levels.

Primary prevention

The primary health care service is in a position to meet people's needs and to deliver health care to individuals or families at their homes or workplaces. It would be quite unrealistic to expect the primary health care worker to develop complex or specialized activities. However, the PHC worker can provide a very cost-effective service by using relatively simple skills of listening, communication, and counselling. In order to develop primary health care services directed towards drug and alcohol problems, PHC workers will have to undertake the interrelated activities described below.

Identify drugs currently used in the community

The PHC worker should learn about the drugs in use locally, as well as the consequences of excessive use. It must be emphasized that information has to be quite detailed. It may be, for example, that a local home brew is mixed with cheap alcohols that are extremely toxic.

Identify the ways in which drugs and alcohol are used in the community

The ways in which drugs are used in a community tend to change frequently. Minor tranquillizers might be used secretly by certain groups, who buy them from a friendly pharmacist or get them through medical prescriptions. Alcohol is supplied without restrictions in many countries, but it will not be easy to find the places where very young children drink cheap alcoholic beverages. There may also be open-air places where children meet to sniff gasoline or glue, under the guise of playing or chatting.

Teenagers and young adults use drugs, or combinations of drugs, according to the fashion. It is also important to detect any intravenous use of drugs, because of the associated infections.

Information and education to promote health

PHC workers are in a position to disseminate relevant information on drugs and alcohol to the community. They can put up posters in the places where most people are likely to see them. They can also distribute reading matter to special groups or organizations, such as parents' organizations. Finally, PHC workers might be invited to conferences on drug- and alcohol-related problems in schools, sporting associations, mothers' clubs, etc. More important than information dissemination is the education of people through a two-way process of communication and interaction. For example, it is quite natural to talk about drug and alcohol problems with pregnant women or young mothers. Most of the time, it will be possible to educate people about the prevention of drug and alcohol abuse without specifying that there is a special programme to combat such problems.

Integrating primary health care work with that of other groups

The PHC worker should work with groups, such as schoolteachers, police, district commissioners, churches, clubs, volunteers, and traditional healers. If the PHC worker is able to develop good interpersonal and leadership skills, he or she will find it much easier to mobilize the community and organize specific voluntary groups to deal with drug- and alcohol-related problems.

Secondary prevention

Identify the immediate effects of drug and alcohol abuse

As the ways of taking drugs change, so do their effects. Whether a drug is harmful or not depends upon the following factors:

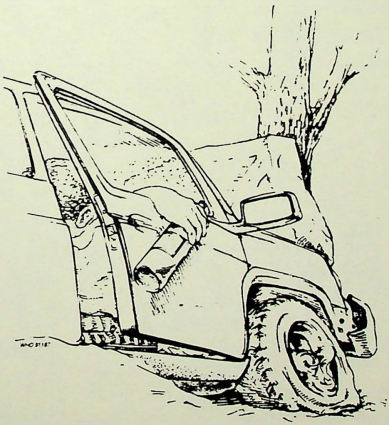
- the user: his or her nutrition, other diseases, etc.
- the drug: its purity, dosage, combination with other drugs, etc.
- the environment: for example, the influence of children who sniff glue together, prisoners who learn to inject heroin, young students who drink at weekend parties.

The effects will be different when drugs are taken in combination: for example, it has become a common practice in Andean cities to smoke, or

sniff, cocaine in order to reverse the effects of alcohol, and to drink alcohol to control anxiety or paranoia provoked by cocaine use. Some people may react very badly even to small quantities of drugs and alcohol; on the other hand, tolerant and dependent abusers are often able to take enormous quantities without showing signs of intoxication.

Identify harmful use and high-risk groups

With some drugs and alcohol, it is often difficult to draw a line between safe and harmful use. For example, to drink 1 or 2 litres of beer may be relatively safe, but this amount could become harmful if taken daily for several years. Celebrating the New Year with three or four drinks could be extremely dangerous if the drinker drives afterwards. Some people stand a very high risk of harming themselves, or others, if they use drugs or alcohol: for example, pregnant women, car drivers, people operating machinery, and those who already have a serious drug- or alcohol-related



Drinking and driving are a dangerous combination.

problem. Others at risk include those with a mental illness or taking medication. Use of illegal drugs is almost always harmful, not only because of the threat to health, but also because of the potential social, legal, and economic consequences. A brief intervention can be very useful with a person in a high-risk group. Such brief interventions are dealt with in Chapter 5 of this manual, and might involve a discussion of the benefits of reducing consumption, as well as of ways of coping without the drug or alcohol.

Tertiary prevention

Identify and manage patients with acute conditions that must be treated without delay

Some acute conditions related to drug and alcohol abuse appear suddenly as emergency problems. The most dramatic are delirium tremens, epileptic fits, confused or agitated behaviour, paranoia, suicide attempts, and the taking of an overdose. When faced with any of these life-threatening conditions, the PHC worker may need to give emergency medication; he or she will therefore need appropriate training and close links with specialist workers.

Identify and manage patients with drug and alcohol problems who must be referred to other services

Some conditions associated with drug and alcohol abuse should ideally be handled in a hospital; for example, epilepsy, liver cirrhosis, peptic ulcer, lung infections, acquired immunodeficiency syndrome (AIDS), hepatitis. There are also some psychiatric conditions that should be referred to a specialist service, and some patients requiring detoxification who should be seen by a hospital service. The PHC worker has to learn which patients to refer, and to whom.

Identify and alleviate family problems related to drugs and alcohol

Besides damaging the brain and the body, drugs and alcohol modify the functioning and control of emotions, desires, thoughts, and perceptions, and also disrupt social and family relationships. The patient may be alienated from all social contact, a vicious circle being established with the patient becoming more and more hostile, and the family more and more unresponsive. Jealousy, violence, unusual patterns of eating and sleeping, fears of being poisoned, and so on, may provoke adverse reactions in other

members of the family. The PHC worker should be able to question family members about these problems, and help them to cope with the emotional turmoil. Chapter 5 covers simple interventions to help families deal with problems and cope with crises.

Helping social rehabilitation

Former drug abusers are fragile beings who have passed through a difficult stage. They need help to readjust to social life and its constraints. The PHC worker should attempt to improve the social relationships of former drug and alcohol abusers, and perhaps introduce them to community self-help and voluntary groups.

Functions of the second level of health care

The second level of health care is usually based at a district hospital. The hospital is staffed by specialists in a range of areas who will see patients suffering from the consequences of drug and alcohol abuse. Registered nurses, social workers, and administrators will all have to deal with such patients. Some training will be necessary for these personnel, so that they can use their knowledge and skills to develop a service to deal with drug- and alcohol-related problems. The functions of this service are described below.

Treating patients referred from primary care

The characteristics of patients vary from one community to another, according to the drugs used, and to their background. Sometimes, guidelines for treating the most common clinical conditions are useful. As an illustration, Table 3 provides an outline of a treatment programme for alcohol withdrawal symptoms in severely dependent patients.

Referral back to primary level

Recovered patients should be sent back to the PHC worker with clear, written indications as regards:

- diagnosis (somatic, neurological, and psychiatric), with comments on expected risks and complications;
- treatment given in the hospital, and the maintenance medication that has to be continued at home, specifying the doses and any expected side-effects;

Table 3. Treatment of alcohol-related syndromes in hospital

Syndrome	Expected complications	Suggested investigations and treatment
Dependence	Withdrawal symptoms	• Mild sedatives (chlordiazepoxide 20 mg orally, 3 times daily) • Vitamin B complex (1 tablet, 3 times daily) • Careful physical, neurological, and psychiatric examination • Laboratory tests: blood, liver, urine • If no complications, discharge in 10 days
Delirium tremens	Epileptic fit Fever Pneumonia Death	• Diazepam (10 mg, intravenously, every 6 hours) • Vitamin B1, thiamine, intramuscularly, every 12 hours • Glucose and saline solutions, 2000 ml, intravenously, every 24 hours • Check temperature, state of consciousness every 3 hours • Antibiotics if necessary • Complete physical examination. Do not discharge before 15 days.
Alcoholic coma	Fractured skull Subdural haematoma Bronchial aspiration Death	• X-rays: skull, lungs • Laboratory tests: blood, lumbar tap • Check vital signs and reflexes every hour

- suggestions for psychosocial interventions, especially ways of supporting or influencing the family;
- indications for future referral, if necessary.

Supplying essential medication

Workers at the primary care level need to have a stock of essential medicines and to know how to use them. Some of these medications must be taken by patients regularly for long periods (e.g., anticonvulsive pills). Other medications have to be given for only a few weeks (e.g., antidepressants, after a suicide attempt). Finally, some medications are necessary for treating emergencies (e.g., chlorpromazine for paranoid agitation induced by cocaine). Second-level personnel should train PHC workers in

the administration of these medications and the prevention of side-effects, as well as in the maintenance of the stock of medicines.

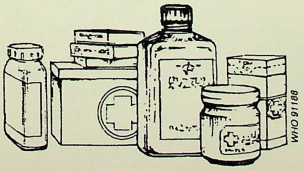
Training PHC workers

First-level health care personnel will usually receive practical training at the district hospital; supervising this training is a key function of the professionals in the hospital. They should also pay frequent and regular visits to primary health care services for the purposes of supervision and consultation.

The changing role of specialists

The role of specialist psychologists, psychiatrists, social workers, and other professionals in a decentralized system is to support the primary health care service by carrying out the following functions:

- They act as educators and agents of social change for the health and other sectors, with regard to drug- and alcohol-related problems, and should attempt to stimulate public awareness of the situation.
- They are consultants for the most difficult cases referred from the primary level; they should avoid being inundated with individual patients who can be dealt with by less qualified staff members.
- They should visit primary health care facilities on a regular basis as consultants and supervisors, and should encourage preventive and curative interventions, as well as simple research.
- They should decide upon the skills and knowledge to be transferred to the lower levels of the service, and prepare the schedules for in-service training.
- They should coordinate and evaluate the whole system, analysing the information collected, and disseminating the results as appropriate.



PHC workers should have a stock of essential medicines.

- They should participate in the development and monitoring of national policies and programmes, particularly those aspects related to financial support and to the employment and placement of former dependent persons.
- They should act as advocates to generate public support and advise local and national authorities, the heads of other sectors, and the mass media on matters related to drugs and alcohol.

New role for the specialist

- Educate, facilitate, and stimulate
- Consult on difficult cases
- Support and motivate PHC workers
- Transfer skills
- Coordinate and evaluate
- Plan and monitor national policies
- Become advocate and advisor.

Coordination with other sectors

To ensure coordination between the various sectors involved, it will be useful to form a community action team (CAT) with representatives from health and other sectors. The members of these teams should be drawn from sectors and groups with a stake in community development. CAT members should be in close contact with members of the community, seeking answers to questions such as:

- What does the community identify as its drug and alcohol problems?
- Who is vulnerable in the community?
- What does the community believe should be done?

The CAT should collect background information on social definitions, perceptions, and responses connected with drug and alcohol problems, as well as on attitudes and the degree of awareness regarding drinking habits and drug use.

It is important that, in all of this, the PHC workers should not see themselves as lone individuals seeking to involve the community. Partnership between health workers, government agencies, social services, and voluntary groups is vital in dealing with drug- and alcohol-related problems in the community. Such problems can never be adequately managed by one person, or sector, working in isolation.

The CAT should coordinate the actions of various interested parties, including health professionals and associations, researchers, law-makers, law-enforcement agents, educators, and community groups, such as women's and youth organizations and churches. Strategies and decisions to develop drug and alcohol programmes should be negotiated by the CAT, or other community committees, which should function at all levels of the health system.

Intersectoral collaboration might also be established using the "gatekeeper" approach: this involves, first, finding out from other sector personnel what they need to know in order to decide whether to collaborate with a health programme. This step stimulates the initial interest. The next move is to find the information they require and pass it on to the other sector, which will then be more likely to act.

Government agencies are usually organized vertically, with representation at all levels but, because of their bureaucratic structure, they often do not develop horizontal collaboration. On the other hand, nongovernmental organizations may be preoccupied with managing their budgets and are often reluctant to develop a partnership for fear of losing their freedom of action. Despite these barriers, the potential of other sectors should be tapped, using the "gatekeeper" technique or another approach, to support drug and alcohol programmes at the community level. Negative attitudes need to be changed across all sectors.

The CAT should coordinate the activities of the various interested parties.

Intersectoral collaboration should be a constant process that must be kept alive by the CAT; the team should organize regular meetings, interactions, and task assignments with community representatives, anticipating as far as possible any likely obstacles and problems.

Evaluation and monitoring

If services for dealing with drug- and alcohol-related problems are organized according to the principles mentioned on page 29—that is to say, decentralized services, with active participation of the community, and undertaken by nonspecialized health workers—it will be important to demonstrate their effectiveness in achieving targets, as well as their efficiency in the use of resources. In addition, health workers, especially those who are not specialized and who work at the community level, need to keep track of what they are doing through feedback from supervisors.

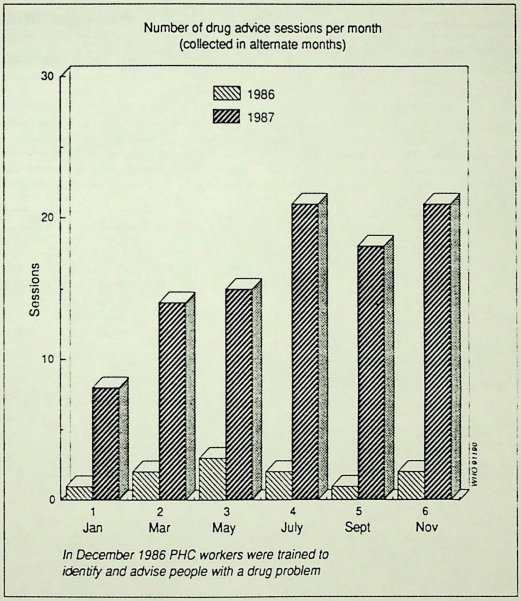
In order to meet these needs, a process of data collection and monitoring is required. Data must be relevant to the everyday work of the PHC worker, and the source of information should be the individual health workers.

Personal contact in the transfer of information is important in order to clarify the relevance of the data, reinforce the motivation for data collection, and give timely feedback. This process can become the basis for continuing in-service training and support for the PHC worker.

Indicators of these activities or of the performance of a team have to be clear and simple. Examples are:

- number of cases per week, and the types of drugs used;
- frequency of visits to families and individuals;
- proportion of cases referred;
- number of contacts with other sectors;
- number of people identified as being at risk;
- number of meetings with self-help groups;
- type and quantity of medications used.

It is also necessary to assess the service and the programme, and to evaluate its management and its relevance to the needs of the community. Information for this evaluation is not always quantitative. Sometimes it will be necessary to carry out formal research. Such research undertakings need not be expensive and can be done as part of a training programme for health workers.



Indicators should be clear and simple, and related to the targets of the programme.

Information on the way in which services operate should be simple and relevant to possible improvements. Such information could be collected by asking questions such as:

- Is there a logical structure for referral and supervision?
- What mechanisms are used to engage other sectors?
- Are drug and alcohol abusers helped in peripheral centres and in the community?
- Are there registries and systems for data collection?
- Does a community action team meet regularly?

Other types of indicator will be needed to show the impact of the programme and its advantages, as reflected in savings in other areas, for example:

- reduction in re-admission rates;
- savings in costs of specialized hospital treatment;
- reductions in incidence and prevalence of drug- and alcohol-related problems.

All this must be accomplished with continuing support and discussion, so that the health workers understand the relevance of the data collection and monitoring.

Training

Training is at the core of decentralization. The delegation of skills and functions means that nonspecialized personnel need to be trained to deliver health care at the peripheral centres and within families and homes. Most of the training should be based on an apprenticeship system, using the attitudes and behaviour of senior personnel and professionals as models. Traditionally, psychosocial and interpersonal skills have been regarded as either inherent and intuitive, or acquired only after a long period of trial and error. This supposition is wrong and needs to be changed.

Effective delegation of skills can be achieved through direct practical training, using a variety of teaching methods, e.g., small group discussions, supervised in-service work, and imitative learning. Essential skills to be taught include:

- interviewing skills;
- ability to listen and to be empathic;
- interpersonal skills needed for counselling, guiding and persuading;
- relaxation, meditation, and culture-specific skills, such as acupuncture, prayer, hypnotism, incantation, and the use of medicinal herbs;
- the management of essential medications;
- the detection of behavioural symptoms;
- a complete approach to problems, incorporating biological, psychological, and sociological points of view;
- recognition of the importance of working with other people in the community, outside the health sector;
- ability to understand and deal with local community fears, beliefs, taboos and attitudes.

The learning of these skills is different from the process of acquiring information and psychomotor skills; it depends on having examples to

imitate, and on frank discussion of what is being done. The aim is to change attitudes by constantly reinforcing positive opinions and points of view. These attitudinal and behavioural changes have to be instilled and shaped from the very beginning of training and continually reinforced.

Budget

Services will operate effectively only if the resources are appropriately assigned. This does not imply extensive financial outlay. On the contrary, an effective alcohol and drug service can reduce overall health costs.

Drug and alcohol services do not demand expensive methods, but rather the deployment of simple skills to the primary health care workers, broadening their approach, and improving their efficiency. The following activities will need to be funded:

- training activities;
- supervision and support from higher levels;
- appropriate means of transport;
- support of coordinating groups (most of them voluntary), e.g., the CAT;
- provision of essential medication;
- establishment of key, multidisciplinary staff members, such as a co-ordinator or community nurse.

In summary, the primary health care worker deals with drug and alcohol problems within the primary health care setting, but works within the wider community and looks to the hospital specialist for support. This may appear to be too much work for a primary level worker. It should be remembered, however, that the system described here is an ideal to be worked towards. The PHC worker should attempt to obtain help from both the community and specialist workers to work out effective ways of providing a primary health care alcohol and drug service within the community.

MH 2-16

Cop

J A G R A N S'

PANTOMIME THEATRE FOR CONSCIOUSNESS RAISING

The pre-requisite for development is liberation from all oppressive structures and attitudes. Such work should lead to the total liberation of men and women. There should be development of the people themselves so that they may understand the issues in a situation and become aware of their own responsibilities.

Jagran's pantomime is meant to educate as well as entertain. The method of work is one that allows the audience to feel part of the act and to become involved in it. The contents are taken from true life situations. This makes it easier for people to place themselves in the act and for them to understand their own situation more clearly. The aim of such an approach is to move people from apathy into awareness and then finally into action. Jagran has been working consistently over the past several years, as a dedicated group. The fact that it continues to use the medium of pantomime as its vehicle for communication speaks for itself.

ITEM	CONCERN	TIME
1. Drug Addiction	Inhibitions, lack of communications, pressures of the community - eventually pushes young people into the traps of drug peddlars who like falcons annhilate those weaker than themselves.	20 mins.
2. Black Marketeer	Poor people rise against black marketing in their slum colonies.	20 mins.
3. Dowry	Humiliation to a point and beyond brings out the strength of a young woman to stand firm against dowry demanding sharks.	20 mins
4. Monster of Malnutrition.	Balanced diet to fight anaemia	20 mins.

.....

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MH 2.17

SYMPOSIUM : SUICIDE

(organised by Lions Club 10th October 1974)

N O T E S:

1. Causes of suicide — Source: Dr. S.S. Jayaram

1. Schizophrenia
2. Depression
3. Personality disorders
   - alcoholics
   - drug addicts
   - psychopaths
4. Depressive neurotics
5. Unbearable physical disease
6. Diseases/conditions producing social ostracism -
   - leprosy
   - leukaderma
   - sterility
7. Old, poor and helpless
   - socio economic disasters
8. Social disorders

- multiplicity of factors
- psycho-social problem

NATURAL HISTORY OF SUICIDE

1. Occurrence of problem

2. Tries to communicate with friends or relatives - the inner conflict

   - behavioural changes
   - c/o depression
   - buys tablets, dolf etc
   - threatens suicide

   State --- of Counselling (time gained)

3. Attempts suicide - successful

4. If unsuccessful --- time lag and may again attempt ------ repeated

2. Hindu view on suicide — Source: Mr. Tandeveshwara

- Karma theory
- unnatural impressions or predispositions (samskaras) due to artificial and sudden end of this existence carries into next existence
- no solution to problem --- since there is merely postponement of working out of 'karma' into another corporeal existence.

3. Christian view on suicide — Source: Fr. Herman D'souza

Suicide - result of a lack of satisfactory working philosophy of life

Negative injunction - Thou shalt not kill

Positive injunction - Thou shalt carry thy cross

4. Islamic view on suicide — Source: Mir Iqbal Hussain

- Liberty with restraint
- Philosophy of life should be - Faith in self and faith in God
- No problems are insurmountable
- You are a trustee of this body and soul and you cannot betray this trust by destroying it.

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5. Social strategies to prevent suicide — Source: Dr. Sreedharan

- No single clear cut strategy will help
- All the social injustices which are causative factors have to be tackled
- Total approach should be stressed
- Family Life Education is an important strategy

6. Suicide and the law — Source: Mr. Nizamuddin DIG

- Law: Sections 305, 306, 309 of Indian Penal Code
- Police dept. would welcome any moves to make suicide a non-chargeable offence
- Police will then only be made to take responsibility of handing over case to a suitable social welfare agency dealing with such cases.

7. Suicide in India/Bangalore - Statistics — Source: Dr. Satyavathi

- Every 0.04 min. one person commits suicide in the world
- Every 10.8 min. one Indian commits suicide
- San Francisco (suicide capital of USA) 1 suicide/36 hrs.
- Bangalore - 1 suicide/28 hours
- Attempted suicides - 80% of cases below 25 years of age
- Method of choice in 1958 - drowning most common
- Method of choice in recent years - insecticidal poisoning
- Suicide represents a sickness of society
- Need for a sound mind in a sound body in a sound society
- "Ambivalence" characteristic of persons with suicidal tendencies. There is a desire to live and a desire to die.
- Place of counselling and other strategies important at this stage of ambivalence
- "Suicide prevention" centres and squads
- Newly developing science - Suicidology
    1. Clinical services
    2. Training - esp of non professional counselling
    3. Research

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MH 218

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REGIONAL TRAINING PROGRAMME ON PREVENTION OF DRUG ABUSE AND ALCOHOLISM SPONSORED BY NATIONAL INSTITUTE OF SOCIAL DEFENCE, MINISTRY OF WELFARE, GOVERNMENT OF INDIA, NEW DELHI

ADDICTION - ITS IMPACT ON THE FAMILY

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

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

The family's reaction to the chemical dependent

In coping with the terror and confusion which surrounds the disease, the family members unwittingly develop and display behaviour patterns similar to the chemical dependent's.

..2.

The family members sometimes let their preoccupation with the chemical dependent cause pain to themselves and destroy their lives.

Denial

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

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

..3.

Blaming

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

Preoccupation

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

methods work. Worry takes over the family - worrying about over dosing, about his physical health, about his being caught by the police and about what to expect next. Family members become so tense, afraid and angry that they begin to question their own sanity.

Bargaining

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

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

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

Depression

Eventually after so many promises, bargains and perhaps even sober periods which have raised hopes and expectations, only to have them dashed repeatedly in new rounds of drug taking, those who are closest to the chemical dependent may plunge into depression, a feeling of complete and utter hopelessness - "Is there no answer to the problem?" This is the stage that may be entered any number of times during one's relationship with the chemical dependent. The family may suddenly realise that loss of income and consequent problems are imminent or they may be saddened by the thought that his health is deteriorating and death is more or less inevitable.

..5.

Suppressed anger

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

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

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

Isolation

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

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

Change of Personality

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

Co-dependency of family members

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

What is co-dependency?

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

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

..7.

Co-dependents suffer from a set of emotional problems. Their strategies of minimising, protecting, controlling, bargaining, appealing are classic coping reactions to the chemical dependent's maladaptive behaviour. The co-dependent suffers from

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

...8.

- Fear of abandonment.

  "What can I do if he leaves me and goes out of the house?"

- Avoidance of conflict.

  "He has not given me any money this month. How am I going to manage? Anyway I'll not ask him. He may get upset and start using ganja again."

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

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

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

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

Help for the family

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

..9.

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

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

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

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

- Start looking after their own needs and the needs of their children. They should realise that they have to start doing their duties which they have neglected so far.

- Identify positive methods of diversion like going to temple, spending time with children, pursuing hobbies etc. Good experiences will give them the energy to face problems.

- Plan one day at a time and start executing their plans.

Problems experienced during recovery

Recovery of the chemical dependent brings a great deal of joy to everyone concerned. The family members may hope that life is going to take a turn for the better at once. They may feel that all their tension will disappear. In a supportive environment, the Counsellor should make them understand that it would be very unrealistic to expect that everything is going to be wonderful

immediately. They should be made aware of the fact that there are certain problems which they may face during the patient's recovery. An understanding will help them handle the problems effectively.

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

*Friends and relatives would all along have admired the tolerance of the family member and would have praised her for bearing the brunt all alone. When the chemical dependent stops taking drugs, the positive comments are likely to be transferred to him. They may even pick on her. "Now that he has given up drugs, why don't you be more understanding? Why do you unnecessarily get angry and shout like this?" These remarks hurt them and it is very common for the close family members to experience extreme bitterness and resentment, especially if they had coped with addiction by suppressing all their feelings.

* Certain actions that would not stir a second thought if displayed by others, may set off alarms in the minds of loved ones when exhibited by the recovering person. It is virtually impossible for the family not to harbour doubts when, for example, they find

some cash missing or when they find the recovering person moody, tired or notice him remaining extra long behind a locked door or getting phone calls at unusual hours.

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

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

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

*Family members will find it very difficult to listen to the recovering person or relate to him in a meaningful way. Even though he may be making positive changes, they may not

acknowledge; instead they may expect him to make changes according to their expectations. For instance, they may make plans for his future. They may ask him to go for work in the mornings, attend classes in the evenings, etc., without discussing the issues with him. They are likely to feel that they have solutions to all his problems.

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

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

..13.

advice and support. There they will meet people who have gone through situations similar to their own. They will understand and identify with the fear, the feelings of helplessness and despair, the worry and guilt and the problems in learning to 'let go' of the chemical dependent. The family members really need and deserve help to recover from this extremely painful family addiction. If they change, it is much more likely that the chemical dependent will want to change too.

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MH 2.19

REGIONAL TRAINING PROGRAMME ON ALCOHOLISM AND DRUG ABUSE

SPONSORED BY

NATIONAL INSTITUTE OF SOCIAL DEFENCE
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NEW DELHI

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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 closer 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.

...2.

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 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

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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 stage 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.

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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

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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 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 actually is.

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"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.

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"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.

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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".

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"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.

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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 consciously 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

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that society will otherwise brand her as 'non-cooperative, unaccomodating 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.

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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.

REGIONAL TRAINING PROGRAMME ON ALCOHOLISM AND DRUG ABUSE

SPONSORED BY

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MOTIVATION AND INTERVENTION

'Motivation' can be defined as the desire to change one's own dysfunctional behaviour. Therefore it is one of the key issues in the treatment of chemically dependent people, and it forms the first phase of therapeutic treatment. In this context, it may be said to include the following:

- totally giving up drugs for life
- attempting to make changes in one's life-style
- realising that it is essential to take an active part in the treatment programme
- be willing to make adjustments in order to recover.

The motivation of a client can be assessed based on the following factors:

- Acceptance of his problem with chemicals
- Asking for help for the same
- Reporting for treatment without coercion
- Compliance with the terms laid down by the treatment centre
- 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. At this point,

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most chemical dependents are self motivated for help. Initially, the client will focus attention on his immediate problems like loss of job, separation from wife, etc. At this juncture, it is not at all advisable to try to make him understand that chemical dependency is his real problem. The most important thing is that, the therapist should show supportive understanding and give him reassurance that his problems will be looked into.

The client will now 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 the client's 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 may 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 [illegible] fear they had during admission and give him reassurance that 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 toward his parents, employer or child. These sensitive areas have to be identified and can be done by attentive, non-judgemental listening - listening to his verbal and non-verbal communicative tion.

"I have come for treatment mainly because my mother is very much 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 therapist'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 client, will in turn, help the latter to accept himself. He will be able to overcome his guilt feelings, self-hate and 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 have irritated him earlier.

By now, the therapist 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 feed back 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 will give him the reassurance that he is not 'alone'. He will come to realise that others had the same or similar problems problems and that they are able to lead a better life without the chemical. He will get reassured that abstinence is possible.

Video presentations have been tried abroad and found to be very effective. This involves 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.

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The client should be encouraged to read materials which give comprehensive information about the disease of chemical dependency. 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 treatment outcome.

Another method which is used for motivating the client, is involving individuals for whom the client has regard and respect. Their involvement in the treatment process will increase the motivation of the individual. Friends or employers who are genuinely interested in his well being may prove to be strong sources of support.

Motivation can be increased by using concrete medical records of the patient. Diagnostic tools like blood reports, CT scans, and X-rays with proper explanation from the medical professional will create an awareness in him about the physical damages caused by his chemical dependency.

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 therapist may be challenged by them again and again. The strength of their 'acceptance' will be tested on numerous occassions. Instead of rejecting the clients or confronting them with logic and argument, the professional should reassure them that he is always there to help and support them and that they are welcome any time for treatment.

However, acceptance of treatment by itself does not mean that motivation is strong. Constant follow up and contact with the professional is necessary to ensure sustenance of motivation, which in turn will lead to a commitment to recover.

We have so far discussed techniques for enhancing the motivation of those clients who have already come to the treatment centre. On the other hand, there may be a group of clients who will be unwilling to come to the treatment centre. In such cases, a family member, usually the wife, or any elder comes to the treatment centre asking for help. Their crucial fear will be "How do we bring him to the treatment centre?"

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What is Intervention?

Intervention is suggested when the addicts refuse to take help inspite of obvious symptoms. Addiction is the only disease where the victim does not fully realise the enormity of his problems. Intervention is a process by which the progressively harmful and destructive effects of chemical dependency are interrupted and the person receives some kind of constructive help. Intervention ensures that a person need not "hit the bottom" before such help can be extended. Intervention is a method by which the reality of his illness can be presented in an acceptable manner. It means getting together and discussing in a caring way the concerns of the family about the person's harmful use of chemicals.

Why Intervention is important ?

* It helps significant people understand how they have been a party to keeping the illness alive and how they can stop enabling the progression of the illness
* It dispels the myth that a person has to "hit the bottom" to have a successful recovery
* It starts a meaningful dialogue between the family members about the problems associated with alcohol/drug abuse and creates a caring attitude towards the addict
* It brings anxiety, fear, pain, anger, isolation and hopelessness into the open and unites people, builds courage and teaches the power and strength of love
* It helps people learn about chemical dependency through a series of meetings with a trained professional
* It leads to a meeting that offers hope to the client

STEPS FOR INTERVENTION

STEP - 1

THE CALL FOR HELP:

It begins with one person who reaches out for help and through that person, a group of meaningful people are gathered. The first person to call for help is generally one of the persons

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closest to the abuser, one who is more worried, afraid and angry than the others. This person can help select other concerned people. In this group it is important to include the addict's children also. Most often they are the ones who listen, witness the fights and anguish, and end up bearing the family's pain. Friends, relatives, employers, clergymen, doctors and others may also be included. The selection of members has to be made by the family with the therapist's help. A group of 5-9 members is a good number for intervention.

STEP - 2

EDUCATIONAL PROCESS

The people who are included in the intervention should know about the disease concept of addiction, the enabling behaviour of the family members and the defence system of the abuser. This education process can be done with one family or a group of several families. The advantage of the group is that the isolation, fear, shame and worry are eased when they come to know that they are not the only ones suffering on account of this problem.

STEP - 3

DATA COLLECTION

A list of specific, non-judgemental facts relating to the abuse of chemicals is presented in a caring manner during the intervention process.

(a)Specific Data : First hand knowledge of incidents and behaviour as narrated by significant people should be reported.The change in the person's character, behaviour,& personality as seen by the concerned persons can be presented. On any account avoid gossip or second-hand information. Avoid generalisation such as "You always drink too much" and "You never come home sober". The person reporting the data should also be encouraged to indicate how it makes her feel - such as embarrassment,fear, unhappiness, etc.

(b) Non-judgemental attitude : Avoid looking down on the person or making moral judgements. Stick to factual reporting of behaviour and incidents.

(c) Care and Concern : The addict should be made to realise that there are people who do care for him and are concerned about what is happening to him.

(d) Plan of action : Decide beforehand as to what type of help you want the chemically dependent to get. If the addict does not accept this, have an alternative course of action, include an 'if' clause.

(e) Consequences : What alternatives does the person face if he rejects all forms of help? Some of the consequences could be highlighted - loss of job, wife separating from him, etc. Do not state conditions that cannot or will not be carried out.

STEP - 4

TREATMENT PLAN

(a) The goal of intervention is total abstinence from alcohol/drugs. The treatment plan is decided by the counsellor and the family members.

(b) Abstinence can be achieved through attendance at AA meetings or taking treatment in a hospital or getting individual counselling or a combination of all the three.

(c) All issues related to taking treatment must be planned in advance. For example, getting medical leave from work, or getting somebody to look after children at home or making some kind of financial arrangements. All these must be preplanned by the family with the help of the counsellor.

(d) There has to be an 'if' clause in case the person is not prepared to take treatment or quit drinking.

The clauses could be:

- Wife will set up another establishment
- Boss will dismiss the addict from the job
- Friends will stop seeing him

The conditions should be realistic, practical and not those which cannot or will not be carried out.

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STEP - 5

FAMILY TREATMENT PLAN

The family is encouraged to seek counselling for themselves so that they can help the addict to seek help. Some of the co-dependency symptoms which the family have are:

1.Rescuing and making up excuses for the addict
2.Feeling responsible for the problem
3.Judging, blaming and nagging
4.Trying to be super responsible
5.Manipulating the dependent
6.Suffering from anxiety, fear and hurt.

STEP - 6

THE REHEARSAL

A rehearsal should be done with the therapist prior to the actual confrontation of the client. The counsellor should guide the meeting. It is helpful to have someone role-play the abuser - perhaps a recovering alcoholic. During the rehearsal, data are presented, treatment plans shared and consequences discussed.

STEP - 7

THE INTERVENTION

Intervention should be done when the addict is likely to be sober. For example, early in the morning, on the workspot, in the place of worship, etc.

SOME GUIDELINES FOR INTERVENTION PROCEDURE

1.Decide on the person who is going to open the session. This person has to state the objectives of the meeting.

2.To break the family's "no talk" rule about addiction, the counsellor should start the session by saying something like, "Your family and friends are here because they are concerned about what is happening to you and to them, due to your drinking/drug abuse".

3.The therapist should also get a verbal assurance from the addict that he will listen without interrupting until all the persons are through with their points for 'talk'. "Everyone in the

family is deeply hurt. Our goal is not to hurt or punish anyone but to identify the kind of help your family needs".

4. Make sure that each fact presented is connected with the use of drug.

5. Avoid interrogations like, "Why do you drink?" "Why did you give your resignation?"

6. Avoid using the word 'alcoholic' or 'addict'. Use 'Problem drinker'/'chemical dependent'. Never get into an argument about 'who an addict is'. While suggesting solutions, it is preferable to use the word 'help'.

7. During intervention, the members should be helped not to get emotional, so that they do not threaten or blame the addict.

8. If the addict tries to change the subject or tries to focus the group's attention on some other problem or person, bring the discussion back to his problem.

9. In case there are a few concerned persons who may not have first hand data, allow them to speak towards the end.

10. Listen for "Surrender" statements such as 'I didn't know it was so bad". Or "I suppose there is something I should do about this". Then focus on the agreed-upon alternatives.

11. Be empathetic with the addict while pointing out realises and provide reassurance. When the person has accepted help, show him your support and care.

12. At the end of the intervention, the professional should be in a position to provide a plan. For instance, fix up a bed in a hospital or fix up an appointment with the doctor on the same day.

13. If the patient is too difficult, don't give up immediately. There is no complete failure to an intervention. The addict may not have accepted help at that point of time. Still the programme would help in bringing out in the open many things which would have been in their mind, and the family members would be in a position to open the talk about the problem later on.

Thus, the task of motivation is to help the patient accept treatment and it is the task of intervention to bring him to treatment.

NEEDED - CHRISTIAN CARE FOR ALCOHOLICS

ALCOHOLISM - AN ILLNESS

The American Medical Association affirms it. Alcoholism is a highly complex and progressive illness. It is treacherous but treatable. There is help for recovery.

What's this illness like? Alcoholism is the condition of a person which is characterized by his loss of control over the use of ethyl alcohol. He finds that he (or she) is consistently unable to refrain from drinking or to stop drinking before getting intoxicated. In brief, alcoholism is uncontrolled drinking of beverage alcohol. This uncontrolled drinking, in turn, causes problems in one or more areas of the alcoholic person's life, such as family life, job, finances, and health.

REASONS FOR CONCERN

It is appropriate for Christian people to be concerned about persons with alcoholism and about their families. Here are some reasons for concern:

- in the United States alcoholism causes intense suffering in the lives of some 9 million men and women alcoholic persons and their 36 million family members, and we people of Christ's fellowship are committed to the relief of human suffering. (It is important to note here that alcoholism ranks as a major health problem in the United States, along with heart disease, mental illness, and cancer. Fewer than five per cent of U.S. alcoholic persons are skid row derelicts; the vast majority of men and women afflicted with this illness live at home in respectable neighbourhood and are struggling to stay in the mainstream of life.)

- the alcoholism illness involves spiritual factors and the specialised ministry of the Church is to supply spiritual resources for the healing of such persons.

- alcohol involvement frequently alienates people of God from the life and mission of the Church and also keeps people from fellowship with Christ and His Church.

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(To assist in the recognition of various stages of alcoholism, a special insert folder, written entirely from the medical-psychological point of view, is provided in the center of this booklet. It was prepared by John C. Flanery, executive director of the Greater St. Louis Council on Alcoholism.)

ORIGINS OF THE ILLNESS

In spite of much on-going research, alcoholism is still an illness of uncertain origins. But it looks as though it is probably caused by various combinations of factors.

What are the probable factors? Apparently among these factors are the physiological; the relational or psychological-religious (those which have to do with relationships with God, self, others, and life in the world); and the social-cultural.

To say it simply, some persons may be or become alcoholics for purely physical or biochemical reasons. Others evidently become alcoholics because their life situation permits or encourages them to solve their relationship problems through the excessive use of alcohol. This use, in turn, becomes uncontrolled because of the development of psychological dependence and quite likely also because of certain changing body functions.

It is important to recognise that persons do not have the alcoholism illness because they are morally weaker than others, more sinful, more stubborn, or more lacking in will power than others. Apparently what happens is this: the alcoholic person's involvement in human weakness and the freedome which he has in deciding how he wants to live combine, somehow, in his associations with people and places, to permit, if not cause, him to use beverage alcohol to deal with God, himself, others, and life in the world. Through his increasing dependence on ethyl alcohol he comes to experience the enslavement of the alcoholism illness.

In no way, however, do the complex and somewhat uncertain causes of alcoholism exempt the alcoholic person from being responsible for obtaining help. The alcoholic

person needs to become, and with help can become, responsible for obtaining treatment.

FOCUS ON RELIGIOUS FACTORS

Let us emphasize a point here. It seems especially apparent that at the outset of and/or during the course of the illness the alcoholic person seeks to deal with his relational (religious and spiritual) needs by means of the anesthetic effects of beverage alcohol. With alcohol seeming to provide some sort of temporary relief from or even a solution to his human needs, he closes himself off from the realistic Christian solution to his human needs. Alcoholism demonstrates how people inappropriately seek in their own way to solve human problems for which God offers an effective solution in Christ and the Christian fellowship.

PROGRESSIVE AND TREACHEROUS

The alcoholism illness is especially treacherous for two reasons that have to do with its progression. First, its progression increasingly damages the whole person - body, mind, and spirit - and this in all relationships. Second, the nature of the illness at its various stages generally precludes the possibility of self-diagnosis and desire for recovery.

The alcoholic person does not readily recognize his condition because he is te,porarily, and at least partially, satisfied with his use of alcohol as a solution for life's problems. When not wholly satisfied, the alcoholic person likely views himself as a bad person or, at times, even insane; and since he does not want to admit to eitcher, he avoids the necessity of seeing his alcohol dependence as a problem.

At any rate, the alcoholic person does not view himself as having an alcohol problem. Instead he usually presents himself in grandiose, egocentric, and demonstrative ways. He makes special use of the defense mechanisms of denial, rationalization, and projection to defend himself

from the dread reality of his situation. It is only when his defenses are weakened by the pain of his drinking that the alcoholic person admits something of his real condition and expresses a desire for change.

RECOVERY BY SURRENDER

As previously stated, there is recovery for alcoholism. Recovery can take place at any stage of its progression. For the vast majority of those who work in the field of alcoholism, this recovery is only by way of total abstinence from beverage alcohol. However, the alcoholic person can move toward recovery only when he gives up completely his use of alcohol as a solution to his human problems. This means that he needs to look upon his uncontrolled use of alcohol as the primary problem in his life and, with hope for recovery, turn to people around him for medical spiritual and psychological-relational help.

Something critical needs to happen in the life of the alcoholic person to facilitate surrender. The alcoholic person needs to experience the inevitable and painful consequences of his alcoholic solution. He needs to have a real life Law experience about his decision to deal with life counter to God's design. Of special importance, he needs to know that his life-style is doing harm to a part of God's creation - his own body - which St. Paul aptly describes as "the temple of God".

It is of greatest importance that the alcoholic person be allowed by those who are close to him to have this Law experience in an atmosphere of love and understanding so that he can see for himself the appropriateness of choosing destructive ways of meeting his needs. But lest the despair, those who are close to him need also to symbolize and communicate to him the hope and concern of the Gospel. They do this by speaking the Good News of God's love in Christ and by being accepting, understanding and genuine in their relationships.

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RESOURCES OF CHRISTIAN CARE

Because alcoholism is very much a problem of inadequate and damaged relationships, the Christian religion offers significant help for alcoholic persons. Christianity truly helps because its basic purpose is the healing of man's broken and damaged relationships with God, with self, and with others.

It's like this: The Christian Good News and its creative thrust into the lives of people meets relationship needs in three ways:

- by giving the alcoholic person the assurance of God's forgiving love and acceptance in Jesus Christ:
- by giving the alcoholic person the ability to give and receive love;
- by giving the alcoholic person a place in the Christian community where there is mutual acceptance, concern, and care.

It becomes clear then that the people of God are uniquely and especially equipped to help alcoholic persons by sharing:

- the acceptance of God in Jesus Christ with all of its power for restoring relationships;
- the Christian fellowship with all of its power to sustain and foster relationships.

Because of the alcoholic person's difficulty in relating well to anyone, including God, we can best help him or her by forming a relationship with the individual by which we make God's love concrete and real as we relate to that person and as we speak the Gospel. Such relationships provide a catalyst which enables the alcoholic person to trust in Jesus Christ for renewal and, at the same time, to begin to build solid relationships with other people.

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CARE FOR THE FAMILY

Caring relationships are important for all members of the alcoholic person's family too, especially for the husband or wife and children. Alcoholism is a family illness. It harms the whole family and injures the feelings, life style, and interpersonal relationships of all family members.

The spouse and other family members often do not perceive the alcoholic person's excessive drinking as the primary family problem but simply as a symptom of various problems for which they often feel they are to blame. Even if family members do look upon drinking as a major problem, they often blame themselves for the alcoholic person's drinking and attendant behaviour. Because they look upon compulsive drinking as being only socially and morally unacceptable, they consequently fail to view the drinking as alcoholism and as an illness.

Family members are inclined to feel both guilty and angry about the alcoholic person's drinking and behaviour and seek to protect him and in some ways, even hostile ways, to force him to stop drinking. Such individuals need help to lead fuller, happier lives and to detach themselves from the tangles of the alcoholic person's drinking and life-style.

SUGGESTIONS FOR ACTION

Here are some specific things Christians can do:

To help alcoholic persons and their families:

- we need to know about alcoholism and be able to identify the illness as early as possible.
- we must view alcoholism as an illness to be treated along with possible underlying problems and causes.
- it is important for us to maintain accepting, understanding, and genuine relationships.

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In our relationships with the alcoholic person we need to:

- lovingly confront him with his drinking problem and give him information about alcoholism.
- help him to accept his uncontrolled drinking as an illness for which he needs help.
- assist him in obtaining medical treatment.
- encourage him to become involved in Alcoholics Anonymous and/or other group therapy programmes.
- provide a Christian sharing group for his growth and benefit.

In our relationships with the alcoholic person's family members help them to:

- understand alcoholism as an illness and identify and accept it as such in the family.
- stop feeling responsible for his drinking and its consequences.
- quit suffering when he is drinking and no longer protect him from the consequences of his drinking.
- free him to experience the consequences of his drinking behaviour.
- shape a more adequate personal life free from drinking and cultivate an openness to receive him back into a full relationship when he is being helped toward recovery.
- become involved with Al-Anon and Alateen (for the teen-age children of al alcoholic person) or other effective therapeutic programmes.

In the interest of Christian concern and care for alcoholic persons and their families, Christian congregations - or groups of congregations - should consider the establishment of a Christian care center or task force to provide supportive relationships and practical assistance.

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For such concern and care our Lord's disciples have received the servant-mind of Christ.

- He involved Himself with all sorts and conditions of people in their need in order to make them whole;

- He humbled Himself and subjected Himself to death on a cross to restore us and all men to our Heavenly Father and to the abundant and eternal life;

- He has chosen us to have and share with others this life that is both abundant and eternal.

A Memento of

THE LUTHERAN HOUR
2185 Hampton Avenue
St. Louis, Missouri 63139.

THE ECONOMICS AND POLITICS OF ALCOHOLISM AND DRUG ADDICTION

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1.00 : INTRODUCTION

1.01 : The drunk on the roadside gutter or the picture of a drug addict in a hospital or jail are the images that usually come to our minds when we try to view from our middleclass perspective the problem related to alcoholism and drug addiction. These stereotyped images of addicts just about reflects a small fragment of the various complex problems related to alcoholism and drug addicts. While looking at the trauma of human suffering we tend to overlook many powerful forces and strong influences that operate in the structure of the society which lay beyond the control of individuals and at times even small communities. Some of these are forces which keep the addicts in the bondage of the drugs and in subtle ways propagate addiction and drug dependency. My intention is in no way to take away the responsibility of addiction from the individual and place it solely on forces beyond him, but to present a realistic picture of these forces so that we may be able to view the problem in a pragmatic manner and work towards effective measures to combat the malady of addiction

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and other problems related to alcohol and drugs.

1.02 : We live in an age and time when politics and economics are the most dominant forces prevailing over every aspect of our lives. While appearing to be under our control they evasively operate in a sphere quite often beyond our reach and influence. We need to understand their dynamics and magnitude in order to effectively influence their course. In presenting this paper it is my hope that I may be able to throw some light on a few of the salient economic and political factors that influence the problems related to drugs. As alcohol is the most commonly and widely used drug we have to deal with it separately apart from other drugs.

2.00 : ECONOMIC FACTORS

2.01 : First of all let us try to understand the magnitude and trend of the problem. The starting point should be the simple economics of production and consumption of drugs including alcohol. There cannot be an increase in production without a natural demand or a well designed and promoted demand. The picture presented by the expert is quite grim. Marcus Grant of WHO comments, "Whilst alcohol consumption is beginning to fall in some Western developed countries, it is continuing to rise steadily on a global basis, with particularly sharp increase in a number of developing countries in Africa, Asia and Latin America. Even though some of these countries were beginning from a comparitively low basic figure, the present trend would, if they continued, lead to very high consumption rate before the end of the 1980's."

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TABLE I

PERCENTAGE CHANGE IN PER CAPITA CONSUMPTION OF ALCOHOLIC BEVERAGES (AS 100% ETHANOL) BY TYPE OF BEVERAGE IN SIX WHO REGIONS, 1970-77

Beverage	Africa	Americas	Eastern Mediterranean	Europe	South-East Asia	Western Pacific
Wine	-16.7	6.9	0.0	- 4.2	0.0	200.0
Beer	9.1	17.1	8.3	15.6	100.0	20.7
Spirits	11.1	8.8	71.4	4.3	20.0	- 24.3
All alcohol	7.3	11.3	12.5	3.0	25.0	- 4.4

From *Alcohol Policies in National Health Development Planning*, WHO Offset Publication No. 89, 1985.

TABLE IV

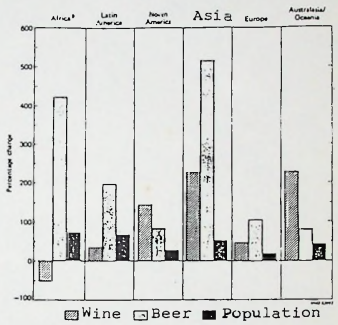
Details of drugs seized during 1985 are as follows: Hindu-July 27, 1986

Drug	Quantity seized (kg.)	No. of cases
Heroin	599.7	63
Morphine	115.2	45
Opium	1,187.02	54
Ganja	53,559.04	152
Charas	7,494.17	93
(1986 up to June 30)		
Opium	253.11	13
Ganja	18,006.35	35
Charas	9,667.595	28
Morphine	14.23	13
Heroin	1,004.29	21

The drug syndicate in India is active in Rajasthan and Gujarat close to the borders of Kutch and Ganganagar. Today heroin is one of the largest as well as fastest selling drugs in India. Its street value ranges from Rs. 1 to 3 lakhs a kg. followed by morphine at Rs. 40,000 a kg, opium Rs. 1,000 to Rs. 2,000, cocaine Rs. 2 to 6 lakhs and hash Rs. 2,000 to Rs. 3,500.

TABLE II

PERCENTAGE CHANGE IN PRODUCTION OF BEER AND WINE IN SIX AREAS OF THE WORLD BETWEEN 1960 AND 1980 COMPARED WITH THE POPULATION INCREASE[a]



[a] Sources of data: (i) International statistics on alcoholic beverages; production, trade and consumption, 1950-1972, Helsinki, Finnish Foundation for Alcohol Studies, 1977 (Volume 27); (ii) Production yearbook, Rome, Food and Agriculture Organization of the United Nations, 1981.

[b] Including north Africa.

[c] The production figures on which these percentage changes are based may be underestimates since they cover only 40% and 73%, respectively, of the world's population.

From *Alcohol Policies in National Health Development Planning*, WHO Offset Publication No. 89, 1985.

TABLE III

Production of Alcoholic Beverages, India, 1970-1977 thousand litres

YEAR	1970	1971	1972	1973	1974	1975	1976	1977
Beverage type								
Indian-made foreign liquor	26 792	27 336	27 788	22 183	26 800	22 396	27 000	95 000
Country liquor	25 380	32 602	34 148	42 579	42 579	25 778	43 000	
Beer	31 123	36 416	50 886	57 728	58 611	57 350	70 000	80 000

(Mohan & Sharma, 1980)[9]

2.02 : With relation to population growth and production of wines and beer the picture does not seem to be too bright. The Asian scene seems to be really disproportionate causing concern.(Table II)

2.03 : One can go on to quote more and more data to prove the point that there is an alarming increase in the production of alcohol over the last couple of decades This is true of the national scene also. (Table III)

2.04 : In a six year period the production of country liquor and beer has doubled. In the foreign liquor front, India has more than 350 brands to chose from. The leading Mc Dowells Company, registers an annual growth of 10%. In the year 1976 the liquor manufacturers used up 169.4 million litres of pure alcohol. In 1981 this went up to 207.9 million litras and in 1985 it reaches 331 million litres which is enough to produce 1134 million bottles of rum (India Today, April 30, 1986). In simple monetary terms at the rate of Rs.50/- for a bottle of rum, this would amount to Rs.5670 crores.

2.05 : We have a similar figure worked out by the seventh finance commission. That the States derive an average of 500 crores of rupees, as excise revenue, on alcoholic beverages. Simple arithmetic will show that the cost to consumer, in terms of money will be in the neighbourhood of 1500 crores (1981 price index)

2.06 : As we can see this relationship between production and consumption in simple economic terms would mean money - a lot of it and all that goes with it. In some cases, multinational and transnational companies are also involved in the production promotion and

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sale of alcohol. It is estimated that US$ 2 billion was the international advertising budget for liquor promotion in 1981. Such is the power and influence behind alcohol and problems related to it.

2.07 : In the national scene there has been increase in production of both Western and country liquor indicating that both the affluent and the poor are drinking more and more. Studies published in 'Current research in drug abuse in India' (D.Mohan) indicate that prosperity in agriculture has contributed more to the liquor consumption than to family health. There are similar studies in industrial areas also to show that the new found affluence contribute towards more alcohol consumption. In the rural areas the poor drink more and more to escape from the harsh realities of socio economic exploitation. It is ironical that the 'exploiter' and the 'exploited' are drinking more and more for reasons of their own.

2.08 : While not wanting to bog you down with statistical details, it is still essential that some information about other drugs are also given. While the production and sale of alcohol is legal in most countries, other hard drugs are taboo and illegal in most parts of the world. This illegality adds to the mystery surrounding the whole drug trade. We come into grips with the situation not by what is consumed or even produced, but by what is seized by law enforcement agencies.

2.09 : According to the UN Commission of Narcotic drugs, Herion seizure till 1951, were less than 100 kg.

In 1977 the haul came up to 2337 kb. 1980 estimated value of illicit drugs in the USA was US$ 80 billion. Today heroin is one of the largest as well as fast selling drug in India. It's street value range from Rs.1 to 3 lakhs a kg. followed by morphine at Rs.40,000/- a kg. Opium Rs.1000/- to Rs.2000/-; cocaine at Rs.2/- to 6 Lakhs a kg; and harshish Rs.2000 to Rs.3500 (Hindu: 7/7/86). The Table IV gives some insight into what has been caught under the legal systems, which is but only a small fraction of the real trade and one can well estimate the enormous amounts of money involved in this whole business.

2.10 : Before going to the political dimensions of the problem, let me touch on a few fallacys with relation to the economics of alcohol. As indicated earlier, the States earn a large sum as excise due to the sale of alcohol and use this argument to legitimise Government involvement in alcohol production and sale. The fact often forgotten is the amount the Government spends in terms of law enforcement, medical care and loss of production which are all resultant of alcohol related problems and these drain away a large portion of what the Government claims to be the gain from liquor sale.

2.11 : Alcohol is an anti development force which saps away human energy and initiative. Though no nationwide survey has been conducted, the Indian Journal of Social Work indicates that 2-4% of persons in most of the metropolitan factories are alcoholics contributing towards absenteeism, poor performance, low productivity, accidents and low morale among others. It is paradoxical here that development

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pays more to the skilled workers, who misuse their money on liquor which in turn adversely affects the very development process. It is fair to categorically state that drug abuse is a deterent to development.

2.11 : For development we require capital, and the formation of this is done through small savings, especially in rural areas. This saving never gets done mainly due to alcohol and drug consumption among the rural masses. Alcohol and drug drain away and arrest the accumulation of funds needed for developmental activities.

2.12 : In the final analysis the production distribution and sale of alcohol and drugs contribute to the wealth of the affluent and powerful , while causing problems to many in economic, social, physical and spiritual terms. In developing countries, like ours, it creates the block market and parallel economy and cripples the very development process.

3.00 : POLITICAL FACTORS

3.01 : Politics, both national and international play a big role in creating and sometimes also effectively eradicating the problems related to alcohol and drugs. It was pointed out earlier that liquor consumption in some of the developed countries are going down while the global consumption is going up. This is done by political decisions of some of the developing countries, by deliberately allowing large multinations to promote and push the sale of alcohol in their countries, at times even by creating a new cultural

ethos so that what is not sold in the developed country, will find an easy market locally.

3.02 : As far as drugs are concerned political conflict and military engagements have proved to create the ideal climate for unscrupulous promotion of drug trade. The Vietnam war has left behind an ugly Asian drug legacy. And today, we have the Afghanistan crisis and the related drug problems which seems to be a serious botheration to the US and Pakistan (Hindu: 22/7/86). Our dailies carry periodic stories of how our neighbours are planning and plotting to promote drug consumption in our campuses and other remote communities near the border. Drug has been reckoned as political weapons to destablise the enemy and demoralising the masses. Wars have been fought over drugs; the opium - war of bygone years to be latest military intervention in parts of Latin America claims the reason for the war to be either for or against the drugs.

3.03: But thanks to UN and WHO today, a number of countries recognising the danger of drug and alcohol are cooperating in many ways to share information and data and work together for the prevention of drug related problems. There are many international agencies that are meaningfully involved in both education and rehabilitation; and through UN help mould the drug policies of the various member countries.

3.04 : Coming closer home to our national scene we find India after Independence adopting a half hearted

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policy towards drugs and alcohol. Prohibition was left to the States as a directive principle (Article 47). Today after three and a half decades of independence all the States of India except Gujarat, have lifted prohibition and liquor is freely available in most parts of the country. Some States have introduced few measures to restrict sale, but we are not quite sure how effective these measures are.

3.05 : In the legal framework we have come a long way in appropriately dealing with problems related to alcohol and drugs. During the British Raj, cannabis was a fact of life. The eight volume: 'Report of the Hemp drugs commission ' of 1894 concluded thus: "The prohibition of ganja is an interference with liberty - which the Government of India is not justified in taking " .Till recently we had the old outmoded opium Act of 1857 and 1878 and the Dangerous Drugs Act of 1930 - providing for 3 years imprisonment with or without fine for drug trafficking. The laws were silent about people caught with illegal narcotic drugs for personal use. In contrast the 1985 Narcotic drugs and Psychotropic substance Bill which has replaced the old ones enhances the range of sentence for drug trafficking from 10 to 20 years imprisonment and fine of Rs.1 to 2 Lakhs.The punishment can go up to 30 years. It also prescribes punishment for those found in illegal possession of narcotics for personal consumption.

3.06 : While the picture concerning the policy is encouraging, the pattern designed for implementation is quite complex and confusing. At the national level,

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the responsibility for controlling and preventing the abuse of drugs is distributed between various Ministries of Government of India, either explicitly or implicitly. For instance, the Ministry of Finance, is responsible for the control of export and import of narcotic drugs (through the Narcotic Commissioner), the Central Bureau of Investigation is usually entrusted with the investigative aspects of the problem in select cases having inter-state or international ramifications. The Ministry of Health is generally responsible for drugs other than narcotics and for the treatment of drug addicts. The Department of Social Welfare is responsible for social aspects of the problem, research and rehabilitation of drug addicts. The Ministry of Education is responsible for prevention and control of the problem among the students and in collaboration with the Ministry of Information and Broadcasting, for creating an elightened public opinion on the subject. Not all these responsibilities are explicitly accepted and many of them are only indifferently performed. Moreover, there is hardly any co-ordination between these different agencies; and to add still further to this fragmentation of a drug policy, all matters relating to alcohol, the most important and commonly abused drug, are left entirely to the State Governments, which are also largely responsible for the implementation of the central laws for the control of drugs. No well-planned and co-ordinated national drug control policy can emerge or be implemented satisfactorily in such a fragmented and unco-ordinated set up.

3.07 : Till recently it has been quite popular for our Government to declare India to be mainly a transit

point for drug trafficking. Wedged between the Golden Triangle formed by Burma, Thailand, and Laos and the Golden crescent comprising Iran, Afghanistan and Pakistan, India has in recent years emerged as the major conduit for opium products. But let us not forget that India is also one of the world's largest producers and exports of opium for legitimate use. There has been questions as to whether all the opium produced in India is used for legitimate supply alone. At any rate there has been a systematic approach of the Government attempting to reduce poppy cultivation in Madhya Pradesh, Uttar Pradesh and Rajastan. From 54000 hectares in the last five years, the cultivation has been brought down to 23500 hectares. Attempts especially in motivating the farmers to look for other alternative cash crops should be initiated with interministerial cooperation to further cut down the present poppy cultivation. New areas of cannabis cultivation such as Kerala and Tamil Nadu with their large tracts under opium (IE 30/8/86) should be kept under strict Government surveilance.

3.08 : As prohibition comes under the State, there has been frequent policy changes concerning this to suit the mood of the masses and at the same time to gain enough in terms of money and power. Tamil Nadu is a good example. During DMK rule in the 70's prohibition was lifted and was quite popular. But without having adequate social and cultural Institutions to accomodate drinking in public, the average drinker found it hard to feel at ease with his new found freedom. And before people could get adjusted to the newness of open sale of alcohol, there came prohibition due to pressure from women voters. The average man became confused and had to change his entire attitude toalcohol consumption and his mode of consumption also underwent devious changes.Before long, once again prohibition was lifted and just fifteen days back (6/10/86) the

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AIDMK has announced that starting with 1987 there will be prohibition once again. These erratic changes of policy, concerning alcohol, many sociologists and experts believe has substantially contributed to growth of alcoholism in the State.

3.09 : Almost all the major States in the Country, have had their share of liquor scandals, the latest being the one for which Sir Ramakrishna Hedge resigned in Karnataka. The liquor contracts, bottling and all associated activities involve big money. The governments are forced to give into the pressures of these Liquor Barons who fund the political parties substantially and look for the spoils after the elections. Though staying in the background the liquor lobby in India is powerful and influential.

3.10 : The Government and political parties are concerned The Congress (I) Party has the All India anti-Narcotics cell chaired by popular film star MP Sunil Dutt. And in Tamil Nadu the Government is reconsidering the introduction of prohibition. It is worthwhile to note that these and other attempts through the media handle the problems related to alcoholism and drug addiction in the down to earth sociological manner. They speak in terms of secular approach rather than moral ones. The famous slogan in Tamil Nadu is 'Kudi Kudiai Kedukkum ' meaning that drinking will spoil the home. Similar ones are there in Maharashdia "Beware drugs are deadly" - "Drugs - the killing fiends. Do not join the living dead " While we are not quite sure how effective these are, they are still worthwhile noting for their secular and sociological appeal.

4.00 : CONCLUSION

4.01 : This has been an attempt to show the power and influence that is behind alcohol and drug trade and the resultant

problems. This should not in anyway discourage our attempts in solving some of these problems. We have only to be cautious enough to realistically understand the forces behind the problem and courageous enough to challenge them in pragmatic terms.

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problems. This should not in anyway discourage our attempts in solving some of these problems. We have only to be cautious enough to realistically understand the forces behind the problem and courageous enough to challenge them in pragmatic terms.

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REGIONAL COURSE ON THE PREVENTION OF DRUG ABUSE AND ALCOHOLISM SPONSORED BY NATIONAL INSTITUTE OF SOCIAL DEFENCE,MINISTRY OF WELFARE, GOVERNMENT OF INDIA, NEW DELHI

DRUG TRAFFICKING - LEGAL ASPECTS

Addiction or abuse of narcotic substances is a worldwide problem. Various countries adopt different measures to curb substance abuse. One commonly adopted measure is legally dealing with the problem by reducing the available quantity and then dealing with pushers stringently.

Geographically, India is sandwiched between the two chief sources of opiates in the world - the golden triangle (Burma, Laos, Thailand) and the golden crescent (Afganistan, Pakistan, Iran). Nepal is situated on the northern borders of the country which has been and continues to be, a major source of Cannabis. Thus, over the years, India has become highly vulnerable to the transit of drugs and this transit traffic has reached alarming proportions.

To meet this challenge, the Government of India took legal, administrative and preventive steps. The first measure, 'The Narcotic Drugs and Psychotropic Substances Act, 1985' was passed by the Parliament and this came into effect from the 14th November of the said year. This enactment also repealed the erstwhile laws and gave sufficient teeth to law enforcement agencies in the form of deterrent punishments to drug traffickers.

The Narcotics Control Bureau was set up as a Central Authority to co-ordinate national and international drug enforcement efforts. It is also responsible for the implementation of the obligations in respect of counter-measures against illicit

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traffic and provides assistance to the concerned authorities in foreign countries and concerned international organisations with a view to facilitate co-ordination and universal action for prevention and suppression of illicit trafficking of drugs. Powers of investigation were vested in Central Agencies such as the Customs and Central Excise Departments, the Directorate of Revenue Intelligence, The Narcotic Control Bureau, The Economic Intelligence Bureau and also with the State Agencies like the State Police Authorities, The State Excise Authorities and the State Drug Control Administration. As a result of this, almost every part of the country was covered with some investigative agencies who have been active in the eradication of illicit cultivation of poppy and ganja.

In order to further strengthen the hands of enforcement agencies, a Preventive Detention Ordinance titled 'The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Ordinance, 1985' was promulgated by the President on the 4th of July 1988. This was subsequently made into a law by an Act of Parliament.

NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES ACT - 1985

Prior to the enactment of Narcotic Drugs and Psychotropic Substances Act, 1985, the statutory control over opium and other drugs (except cannabis) was exercised in India through three Central enactments (i.e.) The Opium Act, 1857; The Opium Act,1878; and the Dangerous Drugs Act, 1930. Control over the cannabis group of drugs was exercised by laws enacted by the state governments. The NDPS was enacted to remove the deficiencies and inadequancies in the old laws and to provide for deterrent punishments for drug trafficking offences. It covers the entire range of

narcotic drugs and psychotropic substances and prohibits their non-medical and non-scientific uses, in compliance with the International Treaties and conventions.

The scale of punishment for trafficking offences prescribed by the Act is shown below:

Sl No.	Description of offences	Minimum		Maximum	
		Imprisonment	Fine	Imprisonment	Fine
1.	Trafficking (Internal)	10 years Rigorous Imprisonment (RI)	Rs.One lakh	20 years Rigorous Imprisonment (RI)	Rs.Two lakhs
2.	Trafficking (International)	10 years RI	Rs.One lakh	20 years RI	Rs.Two lakhs
3.	Trafficking (Internal) in respect of Ganja and Illegal cultivation etc.	-	-	05 years RI	Rs.Five thousand
4.	Trafficking (Internal) in respect of cannabis other than Ganja	10 years RI	Rs.One lakh	20 years RI	Rs.Two lakhs
5.	Unauthorised dealing in drugs outside the country	10 years RI	Rs.One lakh	20 years RI	Rs.Two lakhs

For repeat offences in respect of both narcotic drugs and psychotropic substances (excepting item 3 of table) the minimum punishment would be 15 years rigorous imprisonment and a fine of 1.5 lakhs and a maximum punishment of 30 years rigorous imprisonment and a fine of Rs.3 lakhs. There is also a provision empowering the courts to impose fines higher than the maximum prescribed for reasons to be recorded by them in their judgement.

While providing for deterrent punishments for trafficking offences, the Act envisages leniency towards drug addicts recognising that these unfortunate people who have fallen a prey to drugs, have to be approached with sympathy and should be given a chance to get themselves treated. The persons found to have illegal possession of drugs in small quantities (the variable measures for different drugs which would be deemed small quantity for the purpose of the Act, have been laid down by the Government) are liable to a punishment upto six months imprisonment or fine or both, which in respect of hard drugs like heroin, would be upto one year's imprisonment or fine or both. However, the court is empowered to release the drug addict convict for undergoing medical treatment for drug addiction on his executing the necessary bond prescribed under the Act.

Attempts, abetment and conspiracy to commit an offence are also liable to the same level of punishments as for the offences themselves. All offences have been made cognisable and because of the level of punishment, most of the offences are non-bailable. The Act empowers the officers of various central and state government agencies for searches, seizures, investigations etc.

NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES (AMENDMENT) ACT 1988

On the recommendations of the Cabinet Committee constituted for combating drug trafficking and preventing drug abuse, the Narcotic Drugs and Psychotropic Substances Act, 1985 was amended. The salient features can be briefly stated as follows:

1. It expends the preamble, provides for forfeiture of property used in illicit traffic in Narcotic Drugs and Psychotropic Substances.

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2. A new section 31A provides for death penalty on second conviction in respect of specified offences involving specified quantities of certain drugs.

3. It provides that no sentence awarded under this Act should be suspended, remitted or commuted.

4. A new section provides for pre-trial disposal of seized Narcotic drugs and Psychotropic substances.

5. It provides immunity from prosecution to an addict volunteering for treatment for drug addiction once in his life time. time. The immunity may be withdrawn if the addict does not undergo the complete treatment for the purpose.

Though these legislations have been devised to prevent illicit trafficking, the problem of drug abuse is still growing. What is evident is that drug trafficking and prevention of drug abuse should be tackled on a war footing if this is to be eliminated. It is only the political will of nations and the international co-operation to combat the drug menace on a world-wide basis that can deal effectively with this plague affecting our society.

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BASIC COUNSELLING TECHNIQUES

Counselling is a scientific process of assistance extended by an expert in an individual or group situation to a needy person (s).

The process aims at enabling the individual to learn and pursue more realistic and satisfying solutions to his difficulties. The process primarily revolves around, the relationship between the Counsellor and the Client. It is this relationship that leads to growth and change.

DIFFERENCE BETWEEN COUNSELLING/GUIDANCE/ADVICE/PSYCHOTHERAPY

PSYCHOTHERAPY	ADVICE	GUIDANCE	COUNSELLING
is individual oriented and focusses mainly on early childhood experiences and trauma.	involves an experienced mature adult talking to an inexperienced adult in a subjective tone.	is a comprehensive process which enligtens individuals regarding a new place, subject or situation.	is a specialised function, problem oriented and helps the individual to understand himself and to develop the ability to take decisions and make choices.

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Specific Features of Counselling

Counselling is a series of activities performed in relation to an individual/group and his/ their needs.

These activities are systematically planned and are inter-related.

These activities are carried on over a period of time, the length of which is dependent upon the needs of the client. Counselling sessions are usually held every alternate day initially and once a week or less frequently in the later stages. Each session lasts from 30 to 60 minutes.

In becoming a counsellor and functioning as a Counsellor there are two major aspects one needs to remember:

(i) Quality of relationships and attitudes
(ii) Methods, techniques and skill.

Obviously, quality of relationship is more basic of the two and the development of this special relationship between the counsellor and client is crucial.

Three essential ingredients have been identified in the development of positive treatment relationship.

(i) Accurate understanding of clients.
(ii) Non possessive warmth.
(iii) Genuineness or authenticity.

The Counsellor must be a willing and active intervenor, participant and interpretor of reality.

Basic principles in Counselling

Respect : The ability of a Counsellor lies in communicating to the client the belief that every person possesses the inherent strength and capacity to 'make it' in life and that each person has the right to choose his own alternatives and make his own decisions.

Authenticity + The Counsellor should learn to be genuine, real and honest and not have a 'holier than - thou' attitude, or communicate an 'I am above you' attitude to the client.

Avoid Assumptions: Avoid making assumptions about the client. This means letting the client be the final judge of his own feelings and experiences.

Recognising the clients potential: It is important to recognise the strengths and abilities of the client.

Confidentiality: To maintain confidentality and to develop trust is most important in the counselling relationship.

The Process of Counselling

Stages in Counselling

The different stages in counselling are briefly stated below:

- Making contact in a caring professional role leading to or an appointment for counselling.
- Building rapport.
- Finding out the purpose of the visit.
- Tentative assement of the nature of the problem and approaches in dealing with it.
- Leading to a contract which calls for commitment on the part of the client.
- Process of counselling.
- Feedback and/or follow-up with one or more sessions as per the need of the individual.
- Termination and / or referral.

Activities of a Counsellor

The major activities of a Counsellor in a one-to-one interaction are the following:

1. Establish and maintain a climate for counselling.
2. Case history taking

3. Prepare necessary client reports.
4. Seek consultation from other professionals whenever necessary.
5. Tailor individual treatment plans.
6. Handle crisis situations.
7. Explain the nature of problems.
8. Help client establish contacts with community services.
9. Involve/coordinate other resource persons in treatment.
10. Prepare after care activities for the client.
11. Evaluate client's progress re-define goals if necessary.

SKILLS/TECHNIQUES OF COUNSELLING

The main vehicle through which the counselling takes place is communication. Therefore communications skills are one of the most important skills for the counsellor.

The three element that comprise communication between two individuals are:-

(i) Listening
(ii) Processing
(iii) Feedback

Listening is defined as receiving messages from a client by focusing attention on what the client is expressing, both verbally and non-verbally. Attending is a demonstration of concern and genuine interest in the client.

Processing is the complex series of events that take place within the counsellor between his listening and responding to the client. It may include mentally cataloguing data categorization, of beliefs, knowledge, attitude, feelings, 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.

Feedback skills can be broken down into the following:-

Paraphrasing: A Counsellor's statement that mirrors the clients statement in exact or similar wording.

Example: Client: My boss doesn't understand me at all.
He doesn't realize I'm always shaky
in the morning.

Counsellor: Mornings are a tough time for you.

Reflection on feeling: The essence of the client's feelings either stated or implied, as expressed by the counsellor.

Example: Client: I didn't want to come here. There is
nothing wrong with me. I came to
see you only because my wife insisted

Counsellor: You do not seem too happy about coming here
or
I get the impression that you are annoyed.

Summarizing:

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 summarize the previous session, and at the end, counsellor summarizes the main points of the current session.

SKILLS INVOLVED IN IDENTIFICATION AND
UNDERSTANDING OF CLIENTS PROBLEMS

PROBING COUNSELLOR SELF DISCLOSURE INTERPRETING CONFRONTATION

Probing: A Counsellor's response that directs the client's attention inward to help both parties examine the client's situation in greater depth.

Example: Client: I've been doing this job for years now and nobody ever complained before. Now they're saying my job performance hasn't been as good.

Counsellor: In what ways specifically do they say your work hasn't been good?

Counsellor's Self Disclosure: The counsellor's sharing of his personal feelings, attitudes, opinions and experiences for the benefit of the client.

Example: Client: You know I feel so ashamed. All my friends are going to find out that I have a drinking problem and I don't know how can I 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.

Interpreting. Presenting the client with alternative ways of looking at his situations. Used effectively, interpreting should assist the client to realize that there is more than one way of viewing most situations thereby helping him to apply,

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this kind of unrestricted thinking to all aspects of his life

Confrontation: A 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.

Personal Qualities of a Counsellor

The Counsellor, apart from having a thorough knowledge and perfect proficiency in skills should also possess specific qualities which would be discussed here.

(i) 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 one's own voice".

(ii) Empathy: Empathy means the ability and willingness to perceive life as the client perceives it, without getting unduly involved in it.

(iii) Patience: The quality of patience implies the ability to maintain an equanimity during delays, to remain undisturbed in the midst of obstacles, and keep a non-complaining calmness during the development of failures.

(iv) Integrity: This implies moral soundness and uprightness in the character of the individual.

(v) Emotional Maturity: The ability to maintain a balance and not get unduly swayed.

(vi) Genuineness: The Counsellor's sincere interest in the care and wellbeing of the patient, which in turn, results in his expressions always truly reflecting his thoughts and feelings.

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(vii) Flexibility: Effective Counsellors should be able to adapt both their role and pace according to the client's needs and capacities.

(viii) Self-disclosure: Ability and willingness to share with the client any relevant personal experience.

Combined with compassion, motivation and technical know-how, rich experience are associated with competent counselling.

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CAUSATIVE FACTORS

CAUSES OF ADDICTION

The search for a unitary cause of alcoholism/drug addiction has shifted to inter-disciplinary exploration of factors that might, individually or collectively, account for the development of problem drinking/drug abuse in various types of individuals. Although there is no generally agreed-upon model of how addiction 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 addiction problems, and to improved treatment techniques for those already ill.

Genetic theory

Some workers in the field theorise that addiction may be inherited. Addiction appears to run in families; it is therefore, suggested that an addiction prone individual may have inherited a susceptibility to be influenced adversely by taking drugs Research has provided some evidence to support this theory. The possibility that humans may inherit a predisposition for addiction 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 addiction may be the result of a collection of factors rather than just one.

Learning theory

The learning and reinforcement theory explains addiction by considering drug taking 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

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situations or repelled by unpleasant or tension-producing ones. In the latter case, addiction 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 addicts might appear to contradict the learning theory in the explanation of addiction. The discomfort, pain, and punishment they experience should presumably serve as a deterrent to drug taking. The fact that addicts continue to take drugs ... in the face of family discord, loss of employment, illness and other sequels of repeated bouts is explained by the fact that drugs have the immediate effect of reducing tension while the unpleasant consequences of drug taking behaviour come only later.

The role of punishment is becoming increasingly important in formulating the cause of addiction 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 addict has learned to take drugs under conditions of both reward and punishment, either type of condition may precipitate renewed abuse of drugs.

Ample experimental evidence supports the hypothesis that excessive drug taking 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 cause of addiction in terms of an 'addict personality'. Though it is conceded that all addicts need not have the same characteristics, it is postulated that in the pre-addict stage, a personality pattern or constellation of characteristics should be discernible and should correlate with the predisposition towards addiction. One of the main difficulties in this approach is that the population ordinarily available for study is already in a trouble with addiction. The question is whether the personality traits observed in these people predate the onset of addiction, or are a consequence of addiction

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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 addict patient which would be predictive of addiction. There is evidence that addict 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 addiction than to other psychological disorders.

Cultural theory

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

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 suitable substitute means of satisfaction.

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

Societies may provide alternatives to or substitutes for addiction. Some societies have less stringent sanctions against narcotic drugs and therefore have a lower addiction 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 addiction can be illegal or only illegitimate...acceptable or even sanctified...forbidden or abdominated. Thus, the concept of drug abuse as deviant behaviour is receiving increasing attention by researchers. The deviant behaviour theory represents the addict 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.

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Behaviorist theories

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 if the learned positive effects, such as euphoria, and to avoid the learned negative affects, 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.

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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COUNSELLING FOR DRUG ADDICTION

1. What is Counselling?

Counselling is a deliberate effort to help a person in a rational way to sort out his problems, to clarify the conflicts and issues in his life and to discuss the feasibility of various courses of action. This is done to enable the person assume the responsibility of making choices. It requires knowledge and skill to help the person use available resources to improve his situation.

Counselling is conducted with the purpose of helping the individual become more deeply aware of his situation and of himself in relation to his situation and where change is indicated, to help him find methods to bring about the change.

Counselling process in addiction treatment

The Counsellor provides new information (Problem classification and setting objectives) which leads the patient to

- change his old behaviour and
- adopt new attitudes and values

10 Principles to follow:

- Understand who an addict is, what addiction is, its symptoms etc.
- Addiction is a family illness, hence the entire family needs help and assistance.
- Never refer to addict as a drunkard or a dope.
- In working with an addict, confront him directly with the problems caused by addiction. Since addiction is an illness, counsellor should feel comfortable to talk to the patient about his abuse.
- The convictions and values of addicts will be different from those of others. They may even be distorted. Accept it as part of the disease.

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- Approach an addict with compassion and understanding, not with logic and argument.
- Establish short terms goals for recovery.
- Relapses can occur during the process of recovery. It is important that the counsellor stays with him through this period. He needs great support and understanding at this juncture.
- Maintain confidentiality.
- Ignore the past, use the present for the future. Emphasis should be on potential rather than performance.

Motivation:

During the first contact with an addict, it is essential to find out to what extent he is open to help and what kind of help, if any, he desires. To discover the nature of an addict's motivation, the following questions should be in the mind of the counsellor as he listens and talks to the patient.

- What does the drug addict see as his problem?
- From his point of view, is his drug taking a problem or a solution?
- Does he feel that he needs help from others? If so, what kind of help does he want?
- Does he want some one to pacify his family, intervene with his boss or does he need help to sort out his financial problems?

Generally all addicts have inadequate motivation. More so, if he sees drugs as a solution, or if he wants help in changing people around him, or if he wants to avoid the consequences of his immature behaviour. For some addicts, motivation may be mixed. They may be pulled in opposite directions by inner forces. A part of their mind wants to stop, another part drives them to continue taking drugs.

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At times, the pain of taking drugs and the fear of the probable consequences of continuing the drug, outweigh the craving for the drug. When this happen, the addict 'hits bottom' or becomes open to help.

A hangover period following a binge may be present. "Hitting the bottom" leads to a state of emotional receptivity during which the addict's defences against recognising his need for help, is temporarily cracked by the physical and emotional pain of the experience.

In case of resistent addicts, two principles can be followed.

1. Avoid doing anything which would destroy the possibility of developing a helpful relationship at a later time. Preachings, sermons and pleadings should be avoided.
2. Attempt to sow seeds of understanding of the person and of addiction, which may take root and eventually help the addict to open out and accept help.

"You can't help an addict until he is ready" - This is a dangerous half truth. The danger is that the counsellor will use it to avoid his responsibility which is to discover, stimulate and mobilise the addict's latent motivation towards accepting help.

Initial contact

When an addict meets a counsellor for the first time, he may not admit that he has a problem with drugs. It is not necessary to discuss whether the person is an addict or only an occasional user of drugs. The most important issue is whether he is satisfied with his life, the way it has been going for the past year and whether drugs affected his life in any way.

Most of the addicts have a "motivable area" - a sensitive area where they feel hurt or are aware that they need help. It would be something they are worried about. When the hurt

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areas are discovered, the offer of help is likely to be accepted. These hurt areas could be discovered by encouraging the resistant addict to talk about his drug use/abuse - what he takes, with whom, how he feels, what happens after taking the drug etc.

Early in counselling, the addict will be defensive. He may be much more concerned about his drug abuse, than what he admits to the counsellor. But if the counsellor consciously avoids putting too much pressure on him, he may gradually reveal more of the truth as the relationship grows stronger.

Here are some of the factors which cause the addict to avoid facing his need for help - His fear of the pain of withdrawal, his fear of not belonging to a drinking or drug taking group which he enjoys; his feeling that the drug is all that "works" for him; the blow to his self-esteem on admitting loss of control, his fear of what it might do to his education, family, or social relations to be identified as an 'addict'. It is important that these inner barriers to admitting his need for help, be discussed with understanding and empathy by the counsellor.

Listening:

Listening is the most important technical tool needed by the counsellor. Listening requires suppressing one's urge to interupt, reassure, or ask a series of informational questions. Listening in depth means listening with the third ear, of being sensitive to the feelings behind the words and the subtle messages communicated in mood, posture and facial expression. Intensive listening allows the counsellor to sense how the addict feels about himself, about others and about his problems. Gradually the counsellor begins to grasp precious fragments of understanding of his inner world of hopes, fears, and pain. He begins to see how life looks through his eyes. Listening and responding with warm understanding serve to establish the first strands of the interpersonal bridge called "rapport" over which the counselling process moves back and forth.

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Denial: A major obstacle to long term recovery in the addict is his defence mechanism. It is a psychological mechanism which operates at the unconscious level. Facing the reality of addiction can be very threatening to an addict and this is the main cause for denial. Many addicts keep rationalising their behaviour for so long that they gradually develop 'an almost reflex action' of defensiveness when challenged about their addiction. The label of immorality attached to addiction also contributes to the denial of their problems.

Simple denial: Refusal to acknowledge that addiction to drugs is creating social, psychological and emotional problems.

Minimising: Minimising either the extent of drinking/drug taking or the nature of problems caused by it.

Diversion: Diverting the conversation to another topic.

Blaming: Blaming the family or situation for their addiction.

Emotional Blackmail: Utilising the emotions such as hostility to avoid dealing with the problem of addiction.

Early confrontation with deniers is most ill advised.

- Initial goal in counselling deniers is to have a contract with clients to return to the treatment institution.
- Discuss drug use during initial meetings in a non-threatening manner. (eg.)

"Where there ever times when you feel it was difficult to handle drugs"?

"Have you ever thought of cutting down drugs"?

" How do you think your life might change if you quit using drugs"?

"Let's examine why your parent is so upset about your drug use".

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- Confrontation should be done only after a comfortable relationship is established with the patient, and it should be done in a low-key manner.

- A crisis related to drug abuse or even a hangover may serve as a lead to confrontation. Employing a supportive and non judgemental approach, the counsellor might say, "I guess we're going to have a closer look at your drug abuse."

Relapse:- The addict may avoid facing the counsellor after a slip because of his guilt feelings. Under such circumstances, it may be wise for the counsellor to take the initiative in re-establishing contact. This helps the addict to understand that the counsellor is not judging him or getting angry with him because he had a slip.

The Counsellor's response to resumed drug use should correspond to the severity of the relapse - a brief relapse should be taken in a low-key, sympathetic manner, not an 'I told you so' attitude. A major resumption of drug consumption should be tackled more seriously.

- Counselling should be firm that patients must avoid situations which in the past have elicited use of drugs.

- Analyse feelings of stress that have evoked drug use in the past.

- Signs like irritability, preoccupation etc. which lead to slips, when noticed, should be taken as warning signs of an upcoming slip and necessary precautions should be taken.

- Missed appointments or not attending AA meetings from an otherwise regular person are also warning signals.

Patient being drugged at the time of counselling:

- If the patient is passive, send him back with an appointment for another day.

- Avoid references to his inappropriate behaviour as it is likely that he may become unmanageable. Show a sympathetic attitude till he leaves.

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Counselling Aggressive/Angry patients

Take him to a quiet area; preferably have a third person along. Instead of direct questioning, make supportive statements like 'I know how you must be feeling' etc.

- Let the patient 'blow-off-stream'. Let the addict do the maximum talking
- Resist temptation to disagree.
- Those posting physical threat should be seen in a place where there are people around.
- Avoid retaliatory, hostile remarks that might instigate violence and state honestly that his behaviour is frightening/upsetting you.
- If the patient continues to be threatening, call the police for help.
- Once he calms down, others around can ask the person to leave.
- If the person continues to come drugged, make it clear to him that in future, if he is drugged on the day of the appointment he need not come at all.

Suicidal tendency:

Addicts have a high rate of suicides/suicidal tendencies. The following indications should always be considered seriously:-

- History of previous suicidal behaviour, especially under the influence of drugs.
- References to feelings of futility - "Life is not worth living".
- Pre-occupation with death.
- Recent crisis/loss of a loved one i.e. death, divorce etc.

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- Continued expressions of hopelessness.
- Dramatic mood swings.

If 2 or more of the above indicators are present or if any one appears on a continuing basis, intense psychiatric consultation is adviseable.

Taking Responsibility for Recovery

The counsellor should not give the impression that the addict's lack of sobriety is the counsellor's defeat, or that the addict's success is a victory for the counsellor.

An addict's strong dependency needs, coupled with the role of the parent image of the counsellor, many lead to an unhealthy dependency. It is essential to place the responsibility for recovering on the addict.

Provide Hope and Trust

Instilling a sense of hope in addicts is essential. This will help the patient to learn to trust himself and others.

To relax the patient by using such tools as acceptance, understanding and listening.

To offer assistance to patients in areas where he has serious concerns and the patient seems blocked.

To give reassurance to him that his condition is treatable and changeable.

To set the tone and atmosphere on a positive note giving the patient the opportunity to talk freely.

To indicate to the patient the success of other patients who had the same type of problems as the patient being interviewed.

To accept the patient at the level he is in and not where the therapist thinks he should be.

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Discharge and follow-up

- Patients should be made to understand that recovery is possible.
- They must be encouraged to set new and realistic goals which will help them in recovery.
- Importance of regular follow-up and attendance to AA/NA should be reiterated.
- Patients who are dependent on their counsellors should be encouraged to shift their dependency to AA programme and the weaning should be made smooth.
- Over confident patients should be encouraged to practice the "one day at a time" philosophy.
- Depressed patients should be encouraged to meet the counsellor and doctor regularly.

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PSYCHIATRIC PROBLEMS ASSOCIATED WITH ADDICTION

Alcohol intoxication is characterised by maladaptive behaviour like impaired judgement, belligerence etc. Signs of intoxication include ataxia, nystagmus, slurred speech, flushing of the face, irritability and impaired attention, disinhibition of sexual or aggressive impulses and mood lability.

Alcohol Idiosyncratic Intoxication

This condition is also known as pathological intoxication and is characterized by the sudden onset of marked behavioural changes after the consumption of a small amount of alcohol. The person is confused, disoriented has visual hallucinations, illusions and transitory delusions. There is greatly increased psychomotor activity, impulsive aggressive behaviour or depression with suicidal ideation. This generally lasts for a few hours, terminates in a prolonged period of sleep and the person is unable to recall the episode.

Alcohol Hallucinosis

These are visual or auditory hallucinations usually beginning within 48 hours of cessation of drinking. This may last for several weeks or months without any other signs of alcohol withdrawal or delirium. It may be sometimes accompanied by delusions but the sensorium will be clear.

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Alcohol withdrawal Delirium (DT)

It generally follows the cessation of prolonged heavy drinking. Within hours of cessation the patient has tremors, hyper reflexia, sweating, fever, tachycardia, hypertension, general malaise and nausea or vomiting. Major motor seizures may occur. Patients may have transient hallucinations, illusions or vivid nightmares and disturbed sleep. In addition to this there is a severe disturbance in sensorium manifested by disorientation and clouding of consciousness and fluctuating levels of psychomotor activity ranging from hyper excitability to lethargy. Delusions and agitated behaviour are commonly present.

Alcoholic Encephalopathy (Wernicke's syndrome) and Alcohol Amnestic Disorder (Korsokoff's Syndrome)

Alcoholic encephalopathy is a neurological disease manifested by ataxia, ophthalmoplegia, nystagamus and confusion. This can either spontaneously clear in a few days or weeks or can progress into alcohol amnestic disorder in which the patient has an irreversible short term memory loss in the presence of a clear sensorium. The early acute stage of Wernicke's syndrome responds rapidly to large doses of parental thiamine, as it is believed to be caused by thiamine deficiency. Therefore malnutrition is a pre-disposing factor and heavy alcohol consumption also produces a malabsorption syndrome.

Dementia associated with alcohol abuse

There is impairment in social or occupational functioning which persists at least 3 weeks after cessation of prolonged alcohol use. Other complications of alcoholism such as cerebellar signs, peripheral neuropathy or cirrhosis may be present. It is not yet known whether dementia is a primary effect of alcohol or its metabolites on the brain or an indirect consequence of malnutrition, frecuent head injury and liver disease.

Excessive use of psycho active substances be it alcohol, ganje or heroin is generally associated with psychiatric problems or even underlying personality disorders. In most cases it is difficult to ascertain whether the psychiatric condition preceded or followed the substance abuse. However whether it is a primary problem or secondary to addiction, it is very clear that such problems have to be identified and treated with medications, otherwise it will affect the recovery of the addict.

Given below are few of the problems that may co-exist with addiction.

I)Depression- Depression is the commonest psychiatric problems associated with addiction. The patient seems dull and shows little or no. interest in interacting with others, in eating and in personal appearance. There will also be fatigue, feeling of worthlessness, guilt, morbid thoughts, poor concentration, poor appetite, psychomotor retardation, insomnia or hypersomnia and suicidal thoughts.

Sometimes there may be reactive depression in which the symptoms are less severe. This is the result of a conflicting environment or situation. In such patients anxiety and depression co-exist.

The patient will have to take anti-depressant drugs for 3-6 months depending on the severity of his problems. If suicidal thoughts are present, it will be advisable to shift the patient to a hospital where 24 hours close supervision is possible.

II)Anxiety Disorders - Anxiety is a diffuse, highly unpleasant often vague feeling of apprehension, accompanied by one or more bodily sensations - eg. an empty feeling in the pit of the stomach, tightness in the chest, pounding heart, perspiration, headache, restlessness etc.

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Panic disorder is a spontaneous, episodic and intense periods of anxiety usually lasting for less than an hour.

Both these disorders are more often associated with cannabis use than with other drugs.

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

III)Manic Depressive Psychosis - Only 1-2% of all addicts may have bipolar disorders showing episodes of mania and depression. During the manic phase there is a euphoric mood, with excessive spending, talking, gambling, grandiosity and decreased sleep.

During the depressive phase psychomotor retardation, depression, feeling of hopelessness, suicidal ideas will be seen.

Psychiatric Consultations and continued use of medications are extremely important.

IV)Paranoid Disorders - The dominant symptoms in delusional disorder is a delusion that does not have an identifiable organic basis. The patient's affect is appropriate to the delusion and his personality remains intact or deteriorates minimally over a prolonged period of time. Other signs and symptoms of thought disorder are minimal. The most common delusion is a paranoid delusion in addicts.

V)Other Psychiatric Disorders - Sometimes addicts may also have schizophrenic feature or schizo-affective disorders. These patients may be primarily psychotic with secondary addiction.

Both the above categories recuires prolonged medical help and have to be on anti psychotics under the supervision of a Psychiatrist.

MH 2.28

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"TTK HOSPITAL"
17,4th Main Road,Indira Nagar,Madras-600 020

REGIONAL COURSE ON 'PREVENTION OF DRUG ABUSE AND ALCOHOLISM'
SPONSORED BY NATIONAL INSTITUTE OF SOCIAL DEFENCE,
MINISTRY OF WELFARE, GOVERNMENT OF INDIA, NEW DELHI

VIOLENCE RELATED TO ADDICTION

Domestic Violence is a crime that is committed behind closed doors in the privacy of the family. It is a problem that tends to be denied, ignored or tolerated by our society which has always viewed abuse in the family as a private matter and not a social problem.

"Violence is defined as the last refuge of the incompetent. It is the expression of the emotion, anger taken to a faculty extreme". Domestic violence can also be defined as the maltreatment of one family member by another. It is not only dangerous but also counter productive and despicable.

Violence can be broadly divided into two categories called (1) Primary, (2) Secondary. By Primary, we refer to individuals who have violence as a basic problem, unrelated to contributing factors like mental illness, alcoholism etc. Therefore, it could be due to a personality disorder.

Secondary violence is referred to as violence caused by or as a consequence or outcome of addiction to alcohol or drugs or due to psychiatric disorders.

Domestic violence in the family structure can take different forms such as:

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1)Violence between the couple - Due to incompatability, sex role conflicts, personality clashes, family disputes, disparity in educational or socio economic status etc.

2)Child abuse: A child can get abused in the family, by parents, for reasons like, undue expectations, Lack of parenting knowledge, differential treatment based on the sex, capabilities of the child etc. A handicapped child can get abused. Illegitimate child, a child being put in an orphanage, or correctional home, free hostels, for financial reasons, child labour, step -parents etc would come under child abuse.

3)Abuse of elders: Elders are abused by the children, as they are looked upon as a burden on them. Desire to wrest control of property rights from parents, or old age and economic dependence on children, physical abuse under intoxication, dumping destitute parents to old age homes etc are some of the abuses on elders.

4)Violence within the family due to external factors like: Dowry, property disputes between siblings, marriage against family consent, addiction, mental illness etc can also cause violence within family.

Salient Research Findings

1)Family violence spans all ages, races, nationalities, educational and socio economic groups.

2)Violence is never a one time occurence.

3)Violence is frequent during weekends, holidays and during evenings and early morning hours.

..3.

4) Women are subjected to physical violence and men to emotional violence.

5) Violence is said to be a learned behaviour.

6) There is generally a history of violence in the family.

7) Violence can be directed towards self, others or inanimate objects.

8) Violence can cause severe physical injuries, resulting in suicide or homicide.

9) 90% of the addicts who are violent are reported to be of primary type.

10) 50% of the court cases, related to separation, divorce are attributed to addiction and violence.

Equal and unequal relationships

Violence is often a by product of unhealthy relationships within the family structure. Healthy relationships in a family are normally equal.

Signs of Equal	Unequal relationships
1. Family issues are discussed mutually	One partner will have the final say
2. Women accept a fair deal of unequality	Man expects a fair deal of inequality.
3. Female role expectations	Traditional stereo typed sex
a) nurturing	roles which nurture feelings of
b) dependency	1) Independence
c) care for family welfare	2) Aggression
	3) Control
d) Support for the male in all his efforts.	4) Leadership in man

..4.

Signs of equal	Unequal relationships
4.Both the partners have equal rights	One partner has more rights than the other
5.Mutual respect for one another's feelings, interests and opinion	One of the partner starts giving up one's likes, interests and compromises unwillingly to avoid conflicts
6.No secrets	The partners maintain lot of secrets.

Studies show that for a violent relationship to continue the battern and the battered have certain personality constellations which is given below.

Characteristics of the batterer

1.Poor impulse control

2.Emotional dependency

3.Egoistic

4.Low self-esteem

5.Immature

6.Self-Centered

7.Possessive

8.Paranoid

9.Weak stress management and Poor conflict resolution skills

Characteristics of the battered mate

1.Fear

2.Guilt

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3.Shame

4.Social isolation

5.Low self-esteem

6.Enjoys & encourages spouse's dependency which makes her feel competent.

7.Depression - Suicidal thoughts, attempts.

Characteristics of the abused children in violent relationships

1.Low tolerance

2.Poor impulse and control

3.Depression

4.Hypersensitive

5.Low self-esteem

6.Lying, stealing, other behavioural problems

7.Rebellious

8.Fear

9.Apathy

10.Poor role model

11.Suicidal thoughts / attempts

Cycle of Violence

The dynamics of the violent relations by follows a specific pattern which is termed as cycle of violence. The diagram represents the cycle of violence.

This cycle passes through following stages:

1.Starts with courts ships/dating

2.Decides to marry/or stay together - very loyal and committed to each other.

3.Tension builds - Blames the partner

4.The first violent episode

5.Honeymoon phase

6.Repetition of the cycle

7.Denial of the violent episode

8.Self blaming by the wife

9.Seeking help

10.Ambivalence in and out of relationship.

Why do women stay in such violent relationship?

1)Lack of alternatives.

Economically dependent on the partner.

2)Fear and shame of the unknown may lead abused people to submit to violence. They feel ashamed that the outside world know about their violent relationship.

3)Lack of protection: Neighbours, relatives are not able to render immediate and adequate protection.

4)Ignorance: Unaware of the facilities available to them.

5)Isolation: They have no where to go for support.

6)Cycle of violence: The belief that there are good time as well as bad times. Good days give hope that it may improve with time.

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7) Traditional views of marriage and women - that if the wife had been a better person, this would not have taken place.

8) Low self-concept: After accepting insults, blame, and violence over years many feel worthless. Lack of education, job experience and small children to take care of can make her condition more dependent.

9) Love: The honey moon stage of violence cycle helps them to keep love alive.

10) Threat: Many have been threatened with being killed if they leave the relationship.

11) Secrecy: Since most violence occurs at nights, there is no eyewitness to it and they are unable to voice their difficulties.

Having understood the dynamics of the violent relationship, the following to be worked out in counselling a battered women.

1) Safety for the women and her children - including emergency shelter.

2) Understanding the cycle of violence and processes that perpetuate violent relationships as this may be very helpful for a woman who is trying to explore whether the relationship can be saved and improved or must be ended.

3) Self-esteem: They must be helped to see through their inadequacies and helped to improve and strengthen their skills to develop self-esteem.

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4)Parenting issues: Children in such families often show emotional and behavioural disturbances. It is important that women receive information on these processes to help their children in adjusting.

5)Problem solving and decision making skills: They are often afraid of making any major decisions. It is essential coping skills must be taught.

6)Dealing with the many conflicting and other difficult emotions like anger, fear, guilt, depression and suicidal tendencies.

7)Sex role stereotypes: Many women have poor images of themselves and their roles. They should be empowered to assert themselves and be self sufficient.

8)Alcohol and Drug Abuse issues: Make them aware of the existence of other problems other than violence such as addiction or psychiatric problems.

9)Job/Career needs including training, vocational guidance, placement facilities.

10)Support her to accept initial setbacks. She may go ahead with some step and may draw back because of fear. Reflect her strengths and fears.

11)Guide her to frame her future positively and realistically.

MH 2-29

SHANTI SEVA SADAN : PROJECT PEACE

(Regn No. 31/89 – 90)

DEADDICTION, REHABILITATION, PREVENTIVE EDUCATION CENTRE
FOR DRUG ADDICTS AND ALCOHOLICS

Regd Office : 33, Rest House Road, Bangalore 560 001. Tel : 579307
Admn. Office : 100, Residency Road, C/o Chic Arts India, Bangalore 560 025. Tel : 567609, 568299

AN APPEAL

PROJECT PEACE needs your help — financial aid – help to treat and rehabilitate the DRUG ADDICTS and ALCOHOLICS.

SHANTI SEVA SADAN : PROJECT PEACE is a purely *Charitable* Society & voluntary organisation. It is registered with the Registrar of Societies, Karnataka and with the Income Tax U/S 12A. U/S 80 G (~~due soon~~)

OUR OBJECTIVES AND AIMS are peace and freedom to the addicts and their families; rehabilitation of the drug addicts and alcoholics into society.

We shall organise medical relief and treatment camps ; in-house courses for deaddiction ; group therapies ; Counselling of the addicts and their families etc. We shall organise *preventive education* through all media, Rehabilitation into society and family and *follow-up* work will have an important place in our scheme.
We desire that *you* make our objectives your own.

OUR PROGRAMME will consist of deaddiction (in a hospital), and other renewal programmes that will make our addict brothers new on psychic and spiritual levels. Freedom of conscience/religion of everyone will be respected.

THE BENEFICIARIES of our Peace Project will be all needy addicts (and their families) willing to avail themselves of our service, without any discrimination of caste, creed or status. The deserving poor will be also treated free or at a concessional rate when our funds permit or you find sponsor for them.

DO YOU KNOW THE OTHER BANGALORE ?
A city with 65,000 drug addicts? 150,000 – 200,000 alcoholics ?
A wet city with 2 out of 10 social drinkers tending to be alcoholics some day ?
With addicts (to alcohol / drugs) causing industrial and road accidents ? and 80% absentism, paralyse the economy of the country ?Oh ! Beautiful Bangalore !
Let us keep Bangalore beautiful. Are YOU with us ? Come, Let us promote PEACE. Support PROJECT PEACE.

HOW YOU CAN HELP US :

1. Contribute by cash, Cheque or in kind. (Cf list of our needs,)
2. Introduce us (SSS:PP) to your friends : Speak to them about us.
3. Introduce the addicts to us. And give them hope to live.
4. Spare an hour or two at the Centre in voluntary service.
5. Be a Peace Promoter : Encourage, give company to renewed addicts. They need acceptance ; not condemnation.
6. Sponsor an addict at ' Project Peace '.

We appreciate your positive response and help to light even one candle in the darkness of addicts' lives.

Mr J.R. MATHIAS, B.Sc. (Text.)
Mrs B. VERGHESE
Secretaries

Mr A.B. FONTES, B.Com.
Treasurer

Fr NOEL MENEZES, O.F.M. Cap.
Mr E. A PAIS
President

R: 565434
St Marys Shivajinagar

STATEMENT ON THE NATIONAL CONSULTATION

ON

THEOLOGICAL RESPONSE TO ALCOHOLISM AND DRUG ADDICTION

Dimension of the problem

We are compelled to acknowledge that Alcoholism and Drug Addiction are assuming an alarming proportion in our nation and communities. Individuals who are afflicted by this disease while causing damage to themselves also place enormous burdens on the members of the immediate family and on the community at large. Substance addiction destroys the quality of life and ultimately destroys one's relationship, with God.

We also acknowledge that the problems which cause substance addiction are complex and attributable to physical, psycho-social and spiritual realms. The World Health Organisation and medical psychiatric experts have acknowledged it as a disease which affects people from all kinds of life. The process of healing must be multidimensional. Therefore, we feel that it is imperative that we give a theological response to this human problem which has both moral and ethical implications.

The Human Predicament

This painful human condition is contrary to the will of God and against the purpose of creation. Men and women are created by God in His own image, and endowed with human freedom and creativity.

We through our own self-centredness, self-indulgent ways, and through self-righteousness have failed to responsibily relate to God's creative design. This has resulted in a state of alienation which now exists between ourselves, nature, the world around us and finally between ourselves and God.

Taking alcohol and drugs may begin with an individual decision, but neither the individual alone nor the family are solely responsible for the malady of addiction. There are larger structural socio-political and psycho-pathological forces that are at play here, which are seemingly beyond human control.

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God's Response

We believe that in God we find the purest expression of love agape. It is an expression of sublime and unconditional love which is constantly searching and self-giving. We can appropriate this love, agape, through faith (pistis). Therefore we 'the community of the Faith' who have experienced this searching love of God must attest that agape demands new realities among humankind and that agape itself is the basis of motivation for love bewteen people. The theological reality of the presence of God's love in us must issue a reciprocal response.

The concrete historical expression of agape is in the coming of Christ in order that we may fully understand and experience that loving relationship with God once again. If we say that we have experienced this searching love of God through Christ in our own lives then it is our responsibility to seek and show that we too are agents of love and reconciliation. If we fail to empathise with our brothers or sisters who are affected by substance addiction then we have failed to realise the agape love of God through Christ.

Our Response

Our Theological Response therefore is fundamentally a human response. Alcoholism and drug abuse are realities in our broken world. A person who is an addict stands in need of our love and understanding help. Our Christian Response is to stand beside the needy, be it in spiritual, economic, social or psychological realms.

One of the greatest yet largely untapped resource that we possess is the very fact of Christian Community and fellowship. The word Koinonia denotes communion, fellowship, or participation. An important function of Koinonia is to 'have a share' in the suffering and affliction of others through active assistance!. Through living bonds of Koinonia, we the members of church can actively share and assist each other in the affliction that beset us.

Those of us who belong to the community of the Faith - namely the church, must respond to this need both as individuals and as a whole community. Our earnestness must reach beyond words into deeds, and it is only then that the liberating force of God's love through Christ, can become a reality.

God, through Christ, has revealed His love for all humankind for the restoration of life to its fullness. This universal love fof God transcends human made barriers of caste, creed, colour and nation.

The model of Christ's ministry in His dealing with people with various illness shows us that healing and restoratic was dependent on Faith. We believe that this faith in God's love demands the regognition of the inner strength in each individual which has to be discovered so as to lead one to recovery. God's love and human goodness are essential in our times both on the part of the individual victims and the community, in the process of restoration, healing and wholeness

Jesus has commissioned us to be His partners to heal all infirmities and diseases, to proclaim release from captivity and to bind the broken. In this situation of helplessness we believe that there is an ultimate hope for everyone regardless of the level of despair.

The Reality

What is called for is a caring Christian attitude and way of life. But we discover that there is in the church a lack of awareness of all the facets of the problems related to substance addiction. This is buttressed by an inadequate theological understanding which has made the Church more condemnatory than supportive of suffering addicts.

It is in this context that we took stock of the Church's role in preventing more and more of God's pwople from falling into an abyss of despair and in the arrestingof the discase and in therapeutic and rehabilitatory care. In this context we view every congregation as a healing community . The local congregation must be educated into recognising substance addiction as a multidimensional disease which affects a person's body, mind and soul.

The Pastor is called to an important role in helping the congregation to understand the social, political, economic, ethical cand physical and spiritual aspects of the diseade of addiction and in playing a sensitive and supportive role in identifying addicts and enabling them in their recovery.

In this context we recommend:

1. To the Senate of Serampore and to theological colleges:

   a) That the curriculum be changed to include a comprehensive course in the are of substance addiction, so that pastors who come into Ministry on completion of their education will have sufficient knowledge of the various aspects of the problem and will be equipped to provide a theological and spiritual understanding of the problem to the congregation, the community and to suffering addicts.

   b) that theological students be exposed to the rural and urban socio-political context that aggravates the problem of addiction. Students must also be exposed through atleast year's practical experience, to the various secular and other spiritual programmes already existing in the fields of conscientisation, prevention and treatment.

   c) That theological students who show interest in this Ministry be encouraged to go in for greater specialisation.

   d) that periodic seminars be organised for students and staff on various aspects of substance addiction. Experts and recovered addicts can be invited to speak.

2. To national bodies (NCCI, CMAI, CBCI,)Board of Theological Education, Serampore Senate etc.

   a) that attempts be made to bridge the existing gap between theological institutions and the church, by bringing together curriculum planners and bishops/heads of churches to ensure that theological education will be geared to the needs of the grass root level local church and the community.

   b) that attempts be made for every Christian medical hospital in India to have a unit for de-addiction and psychotheraphy.

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c) that national bodies and the churches will make every effort to conscientise the people of the negative consequences of substance addiction by organising awareness camps, seminars, training programmes and work-shops and giving publicity through Christian and secular journals etc.

d) that media resources be identified and exploited to deducate people of the effects of addiction and to educate addicts to recognise their responsibility for their actions so that they can make a positive contribution to society.

e) that appeals be made to the government demanding proper implementation of excise laws.

f) that appeals be made to the concerned Chief Ministers and the Prime Minister documenting the reality of non-compliance with excise laws.

g) that a definite stand be taken against the production and marketing of addictive substances.

h) that every opportunity be taken to participate in and express solidarity with all forces working towards concientisation and prevention of abuse and in the treatment of addicts.

i) that one Sunday in a year be declared and celebrated as 'drug awareness day'.

3. To the local church/pastors we recommend

a) that lay training programmes (eg. TECCA OF ITS and TAFTEE)

b) that Pastors and elders themselves be temperate and live exemplary lives.

c) that the addicts be equipped to be able to identify addicts, counsel them and refer them to professional care and to programme such AA.

d) that the church buildings be made available to spiritually oriented groups such as AA for their meetings

e) that the programme of Sunday School (eg. AISSU/ ISSU/VBS) youth groups, confirmation classes, women's fellowship groups etc. include awareness building and support work on substance addiction.

f) that drug awareness programmes be organised for school children, college students and the general public.

g) that pastors through sermons, pre-marriages counselling bible study conventions, sensitise the Church to problems related to addiction.

h) that recovered addicts to be invited to the regular church service to give their testimony so that the congregation will be able to respons to them positively snd with empathy. Addicts need a sense of belonging in order to reduce anomie and alienation.

i) that healthy parenting ideas be fostered through family life education so that parents will always be available to children helping to ease stresses with regard to modern day competitiveness and creating an atmosphere of loving and caring.

j) that team ministries be initiated and small prayer groups/theraphy sessions be encouraged for two or three families who face the problem of addiction, Peer group support plays a crucial role in the recovery process and must be encouraged.

k) that ecumenically organised 24 hour centres of deaddiction day care centres and half way homes and after care centres be set up in each area fully equipped with mnot only medical but also psychiatric care, counselling and spiritual programmes. The Church should should provide inexpensive and subsidised care wherever necessary.

l) that the local congregation support every effort to curb easy availability of addictive substances, joining in protexts wherever possible regarding improper location of liquor shops and bars.

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REGIONAL COURSE ON THE PREVENTION OF DRUG ABUSE AND ALCOHOLISM SPONSORED BY NATIONAL INSTITUTE OF SOCIAL DEFENCE, MINISTRY OF WELFARE, GOVERNMENT OF INDIA, NEW DELHI

COMPREHENSIVE MULTI-DISCIPLINARY APPROACH

A comprehensive treatment program, presented by a multi-disciplinary team has been found to be more beneficial.

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 adolescent may be going through.

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Information, assessment and referral services

After identification, they are brought to assessment centres. These organisations are located in industries, 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 which motivate the patients to take further treatment. Referral to appropriate treatment programme for continued care is also made.

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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 the therapeutic activities like cleaning the room, helping in the kitchen, watering the plants in the treatment centres, 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 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 pharmacological 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 resocialisation of the individual, as part of their rehabilitation.

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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

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.

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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.

Phase	Goals	Methods	Settings
Phase I Identification/Intervention	* Problem definition * Patients entering treatment	* Breaking of denial through empathetic, non-judgemental, supportive, confrontation	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	Out-patient emergency care services, in-patient hospital or detox services.

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Phase	Goals	Methods	Settings
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, Therapeutic Community
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 Self-help groups.

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REGIONAL COURSE ON THE PREVENTION OF DRUG ABUSE AND ALCOHOLISM SPONSORED BY NATIONAL INSTITUTE OF SOCIAL DEFENCE, MINISTRY OF WELFARE, GOVERNMENT OF INDIA,

HIV AND AIDS

Human Immunodeficiency Virus (HIV) was first discovered in 1983-1984. It is the virus responsible for causing the disease known as the Acquired Immunodeficiency Syndrome (AIDS).

The first AIDS case in India was reported in May 1986. Since then many have been reported and by 2000 it is estimated that nearly five million people in India would be HIV positive and the number of full blown AIDS cases would exceed one million. No one knows exactly how many cases are infected today but for every one case reported, 100 would be unreported in the general population.

Spread of the Virus

The virus is spread by the following routes:

1 - Sexual intercourse - heterosexual
homosexual

2. - Needle sharing by intravenous drug abusers

3 - Pregnancy from mother to foetus

4 - Transfusion of blood and blood products

Pathogenesis

The HIV infects specific white blood cells and destroys the T_4 lymphocytes. This is essential for the body's immune defence system and when these cells are destroyed the infected person becomes susceptible to a range of opportunistic infectious disease and cancers. AIDS is the term applied to a group of such conditions, the presence of which indicates severe damage to the

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immune system. HIV may also infect the nerve cells, causing neurological disturbances. HIV infection is lifelong and the infected person remains infectious for life.

Rate of Progression to AIDS

All those who are infected with HIV will develop AIDS within 5 - 12 years and those who are diagnosed as AIDS die within three months to two years. The patient is the most infectious during the window period and just before the development of AIDS.

Person infected	Asymptomatic Appears normal Patient is HV + ve Infective	AIDS	Death
3 - 6 months	6 mths to 5-12 yrs	5-12 yrs	2 months-2 yrs
Window period			
Pt shows HIV - ve but is infectious			HIV +ve Has infections or Cancers

Manifestations

Acute Prodromal Manifestations

It generally precedes the development of an antibody response (seroconversion) or during the so called window period. The typical signs are fever, lymphadenopathy, night sweats, skin rashes, headache and cough.

Stage - 1

The patient is either asymptomatic or presents with persistent generalised lymphadenopathy - characterised by lymph node enlargement to greater than 1cm in diameter involving two or more extra inguinal sites and lasting for atleast for three months. The duration of this phase may range from a few months to many years.

Stage - 2 (Early disease)

This stage is characterised by the occurence of typical mucocutaneous lesions such as oral hairy leukoplakia or infections such as herpes zoster. Constitutional manifestations such as moderate weight loss, fatigue, anorexia and night sweats are frequently intermittent. Recurrent upper respiratory tract infections may also occur.

Stage - 3 (Intermediate disease)

In this stage oral candidiasis, oral hairy leukoplakia, pulmonary tuberculosis, labial or general herpes, viral vesicular dermatitis and other bacterial infections causing pneumonia or gastroenteritis and a tumor called Kaposi's sarcoma can occur. Constitutional symptoms include persistent fever, diarrhoea and weight loss exceeding 10% of body weight.

Stage - 4 (Late disease)

There is profound immunosuppression so there are severe problems caused by opportunistic infections (pneumonia, fungal infections, etc.), severe forms of lymphoma and cachexia may also occur. This is the last stage.

Neurological Manifestations

The most frequent neurological disorder is subacute encephalopathy characterised by progressive behaviour changes associated with dementia, it occurs in one third of the people with late stage HIV infection. Its onset is gradual with tremors, slowness of movement, memory loss and peripheral neuropathy and aphasia. The course is usually progressive towards sever dementia. Mustism, incontinence, loss of vision and paraphlegia may develop in terminal stages.

...4.

Prevention Strategies

1. Sexual transmission

a) Having single mutually faithful relationship

b) If a person insists on having multiple sexual partners - using condoms from start to finish for all sexual penetration - vaginal, anal and oral

c) Avoiding sex with people who have many partners (eg. prostitutes)

2. Parenteral transmission

a) All blood and blood products have to be checked for HIV before using.

b) Needles, syringes and other skin piercing instruments have to be cleaned with bleach and then sterilized.

3. Behaviour change for IVDU

a) Abstain from drugs

b) Change from IVDU to chasing or smoking

c) If a person insists on IVDU at least use disposable syringes and needles or sterilised ones and never share them.

4. Perinatal transmission

Females who are HIV positive should not get pregnant as there is a 40% chance that the child will be positive too.

HIV testing

There are 2 viruses HIV & HIV 2 and Elisa Kits are available for both. Elisa test is a simple inexpensive procedure by which HIV testing can be done. If the person is tested positive, either repeat the test using another sample of blood or send for Western Blot method. Western Blot method is more expensive and done only in a few centres.

Pre-test counselling

I. Assessment of risk

a) Frequency and type of high risk sexual behaviour - eg. multiple sexual partners or unprotected sexual relationships with prostitutes.

b) Intravenous drug use - specially as a group activity with sharing of syringes and needles.

c) Having received blood or blood products

d) Non-sterile invasive procedures like tattooing

e) Difference between HIV +ve & AIDS to be explained

II. Assessment of psychological factors and knowledge

a) Why is the test being requested?

b) What particular behaviour or symptoms are of concern to the client?

c) What are the client's beliefs and knowledge about HIV transmission?

d) How would the client react if he is positive or if he is negative?

e) Who could provide emotional and social support to the patient- family, friends or any others?

f) Talk about the window period

g) How can a change in behaviour reduce the likelihood of transmission?

Post-test counselling

I. After a negative result

a) Possibility of a window period so need to re-check after six months

b) Further exposure to HIV infection can be prevented only by avoiding high risk behaviour. The patient is not immune to HIV as he may misguidedly think.

..6/-

c) It may be necessary to give information on control and avoidance of HIV infection by development of positive health behaviour and repeat explanations.

II. Counselling after a positive result

The result should be told as early as possible clearly and the patient should be given time to absorb the news. Wait for some time. After a period of preliminary adjustment, the patient should be given a clear factual explanation of what the news means. Do not speculate about prognosis or estimate time left to live. It is a time for offering support and hope for achievable solutions to personal and practical problems that may result.

Psychological issues

1. Fear
2. Anxiety
3. Grief
4. Guilt
5. Depression
6. Denial
7. Anger
8. Suicidal activity or thinking
9. Low Self-esteem
10. Hypochondria and obsessive states
11. Spiritual concerns

Other Issues

1. Social issues - environmental and social pressures such as loss of income, discrimination, social stigma, relationship changes and changing requirements for sexual expression. The patient's

perception of the level and adequacy of social support is of vital concern and may become a source of pressure and frustration.

2. Medical management - Counselling may help the patient to gain access to appropriate medical care and day to day management.

CREST

(Centre for Research Education Service & Training)

No. 14, High Street, Cooke Town, Bangalore-560 005

WE OFFER COUNSELLING & GUIDANCE TO :

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and for Smoking, Alcohol and Drugs

at our Centre, Monday to Saturday between 9-30 a.m. and 4-30 p.m. (Ph. 577547)

at State Youth Centre III Floor, (Hobby Hall), Nrupathunga Road, Bangalore-560 002
(Opposite St. Martha's Hospital)
From Monday to Saturday between 4 p.m. & 6 p.m.

WE UNDERTAKE TO CONDUCT :
Smoking, Alcohol, Drugs & Family Life Education Programmes in Colleges, High Schools, Institutions, Industries and Organisations on request.

APTITUDE TESTING : for students on Tuesdays and Thursdays at State Youth Centre, between 4 p.m. and 6 p.m.

PLEASE CONTACT US FOR FURTHER DETAILS

HOW DO YOU KNOW

YOU are an alcoholic ?

Based on extensive researches, here's a check-list of test questions used by JOHNS HOPKINS UNIVERSITY HOSPITAL to determine whether a patient is alcoholic or not. YOU are not answerable to anyone, but YOURSELF : for, the prize is your own SURVIVAL, SANITY, SOBERITY and SELF-FULFILMENT !

TEST QUESTIONS :

1. Do you require a drink the next morning ?
2. Do you prefer to drink alone ?
3. Do you lose time from work due to drinking ?
4. Is drinking harming your family in any way ?
5. Do you crave a drink at a definite time daily ?
6. Do you get the inner shakes unless you continue drinking?
7. Has drinking made you irritable ?
8. Does drinking make you careless of your family's welfare ?
9. Have you thoughtless of your husband or wife since drinking ?
10. Has drinking changed your personality ?
11. Does drinking cause you bodily complaints?
12. Does drinking make you restless ?
13. Does drinking cause you to have difficulty in sleeping ?
14. Has drinking made you more impulsive ?
15. Have you less self-control since drinking ?
16. Has your initiative decreased since drinking ?
17. Has your ambition decreased since drinking ?
18. Do you lack perseverance in pursuing a goal since drinking ?
19. Do you drink to obtain social ease? (In shy, timid, self-conscious persons.)
20. Do you drink for self-encouragement ? (In persons with feelings of inferiority)
21. Do you drink to relieve marked feeling of inadequacy ?
22. Has your sexual potency suffered since drinking ?
23. Do you show marked dislikes and hatreds since drinking ?
24. Has your jealousy in general, increased since drinking ?
25. Do you show marked moodiness as a result of drinking ?
26. Has your efficiency decreased since drinking ?
27. Has drinking made you more sensitive ?
28. Are yon harder to get along with since drinking ?
29. Do you turn to an inferior environment since drinking ?
30. Is drinking endangering your health ?
31. Is drinking affecting your peace of mind ?
32. Is drinking making your home life unhappy ?
33. Is drinking jeopardizing your business - your job ?
34. Is drinking clouding your reputation ?
35. Is drinking disturbing the harmony of your life ?

WE, IN ALCOHOLICS ANONYMOUS, would ask even more . . .

36. Have you ever had a complete loss of memory (black-out), while or after drinking ?
37. Have you ever felt, when or after drinking, an inability to concentrate ?
38. Have you ever felt "remorse" after drinking ?
39. Has a physician ever treated you for drinking ?
40. Have you ever been hospitalized for drinking ?

SCORE RATING : If YOU have answered YES to any one of the test questions, it is a warning that YOU may be an alcoholic, if YES to any two, the chances are YOU are an alcoholic; and if YOU answer three or more, YOU are definitely an alcoholic.

IF YOU seek NEW LIFE for OLD.....
ASK YOURSELF.....

DO YOU WANT TO

1. Become a real person ?
2. Face realities ?
3. Break the alibi-excuses habit ?
4. Face responsibilities instead of resorting to emotional fatalism ?
5. Realize that you cannot eat your cake and have it ?
6. Reeognize that you, and not circumstances, is your major problem ?
7. Acknowledge that your trouble lies in being allergic to yourself rather in than in the dirty deals life has dealt ?
8. Admit that you have had more trouble with yourself than any other man or woman you know ?
9. Believe that only if a man can accept himself, is he fit for married life or any other form of constructive life ?
10. Eliminate fears, and turn into a plus ?
11. Tackle yourself, when depression comes, and not blame circumstances ?
12. Learn that to put yourself in second place is the whole significance of life ?
13. Make first place your desire to help and to rehabilitate unfortunate alcoholics ?
14. Cultivate a spiritual faith even though you go no further than believing in an ultimate decency ?

IF Your Answer is YES, YOU can ACHIEVE. . . .

A : You can bend any events (good or bad) to your own improvement.

B : You will not cower to human opinion or fashion but look to higher law dictated by your own self-respect.

C : You will automatically use your freedom to resist the bondage of habit.

D You will fraternize with congenial company and acquire true and genuine friends.

E : You will learn to enjoy guarding your own intellectual rights.

F : You will auto natically forget the past and listen for higher and finer notes from your better self.

G : You will then be true to yourself, not false to any man.

H : You will, then, possess true self respect, through honesty, which will develop humility and a degree of understanding of life's technique.

WHEN ANYONE, ANYWHERE HAS A DRINKING PROBLEM, ALCOHOLICS ANONYMOUS CAN HELP RECOVER

A A PALI EVENING GROUP

TPS III, ST. THERESA'S HIGH SCHOOL,
BANDRA. BOMBAY 400 050,

MEETINGS : SUNDAY – 7 p.m.

We Welcome Co-operation of :
Doctors, Social Workers, Family Counsellors & Labour & Personnel Officers and Public – Spirited Citizens

ALCHOHOL DEHUMANIZES !

ALCHOHOL RUINS HEALTH !

ALCHOHOL DESTROYS FAMILIES !

This is the plea of thousands of toiling women and men, who have come together as a powerful force to campaign against alchohol and bring about prohibition in Karnataka.

1995 saw women and men from all walks of life coming together to protest against alchohol and their efforts were duly recognised by the then Chief Minister and the present Prime Minister Shri. H. D. Deve Gowda. Who promised to enforce prohibition by June 1996.

But alas ! the Government made mockery of its promises and assurances and have postponed the prohibition to July 1997, all in the name of losing **revenues** and lack of personnel / infrastructure to manage the after effect of prohibition.

This is a sham which no conscious citizens will ever tolerate.

Loosing revenue at the cost of hundreds of lives of women, Psychological complications of thousands of children in families is not an excuse to be considered by the Government. It was the promise of prohibition that elected the present government to rule. women voted for it with the hope of better lives. we are **Cheated !!!**

Thus we call upon you to join us for the protest Dharna and fasting on the **2nd October 1996 from 10-00 a.m. to 4-00 p.m.** after which the Memorandum will be presented to the Governor.

Meeting Venue - Mahathma Gandhi Statue, M.G. Road.

It is our United power which can save our families.

Come and be with us.

MAHILA PRAGATHI - WOMEN'S DESK

&

OTHER WOMEN'S ORGANISATIONS, BANGALORE.

ಮದ್ಯಪಾನ ಮಾನವತೆಯನ್ನು ಕೊಲ್ಲುತ್ತದೆ !
ಮದ್ಯಪಾನ ಆರೋಗ್ಯವನ್ನು ಹಾಳುಮಾಡುತ್ತದೆ !
ಮದ್ಯಪಾನ ಕುಟುಂಬಗಳನ್ನು ನಾಶಮಾಡುತ್ತದೆ.

ಮದ್ಯಪಾನ ವಿನಾಶಕ್ಕೆ ಕಾರಣ

ಕಳೆದ ಕೆಲವು ವರ್ಷಗಳಿಂದ ಬೆಂಗಳೂರಿನ ಹಲವಾರು ಮಹಿಳಾ ಸಂಘಟನೆಗಳು ಸಾರಾಯಿ ಸಂಪೂರ್ಣ ನಿಷೇದಕ್ಕೆ ರಾಜ್ಯದ ಮುಖ್ಯ ಮಂತ್ರಿಗಳಲ್ಲಿ ಮನವಿ ಮಾಡುತ್ತಲೇ ಬಂದಿದೆ. ಇವೇ ನಿಟ್ಟಿನಲ್ಲಿ ಆಗಿನ ಮಾನ್ಯ ಮುಖ್ಯ ಮಂತ್ರಿಗಳಾದ ಹಾಗೂ ಈಗಿನ ನಮ್ಮ ಪ್ರಧಾನ ಮಂತ್ರಿಗಳಾದ ಶ್ರೀ ಹೆಚ್. ಡಿ. ದೇವೇಗೌಡರು ಜೂನ್ 1996 ರಿಂದ ಮದ್ಯಪಾನ ನಿಷೇಧಿಸುವ ಭರವಸೆ ಕೊಟ್ಟಿದ್ದರು.

ಆಶ್ಚರ್ಯವೆಂದರೆ, ಈಗಿನ ನಮ್ಮ ಮುಖ್ಯ ಮಂತ್ರಿಯವರು ಈ ವರ್ಷದ ಆಯವ್ಯಯಕ್ಕೆ 650 ಕೋಟಿ ರೂಪಾಯಿ ಕೊರತೆ ಬೀಳುತ್ತದೆಂಬ ಕಾರಣಕ್ಕಾಗಿ ಮುಂದಿನ ವರ್ಷದ ಜುಲೈ ಅಂದರೆ 1997ರ ಜುಲೈತಿಂಗಳಿನಿಂದ ಮದ್ಯಪಾನ ನಿಷೇದ ಜಾರಿಗೆ ತರುವುದೆಂಬ ನಿರ್ಧಾರ ನಾಚಿಕೆಯವಾಗಿದೆ. ನಮ್ಮ ರಾಜ್ಯದ ನೂರಾರು ಮಹಿಳೆಯರ ಕಣ್ಣೀರನ್ನು ಕಡೆಗಣಿಸಿದಂತಾಗಿದೆ.

ವರ್ಷಾನುಗಟ್ಟಲೆ ನೆನೆಗುದಿಗೆ ಬಿದ್ದಿರುವ ಈ ಸಾರಾಯಿ ಸಮಸ್ಯೆಯನ್ನು ಸಂಪೂರ್ಣವಾಗಿ ತೊಲಗಿಸಿಲು ಈಗಿನಿಂದಲೇ ಪಣತೊಟ್ಟು ನಾವೆಲ್ಲರೂ ಒಟ್ಟಾಗಿ ಹೋರಾಡೋಣ.

ಬನ್ನಿ ನಮ್ಮೊಡನೆ ದನಿಗೂಡಿಸಿ.

ಸಾರಾಯಿ ನಿಷೇಧದ ಭರವಸೆ ಇತ್ತು.

ಓಟು ಗಿಟ್ಟಿಸಿಕೊಂಡಿರುವ ನಮ್ಮ ಸರ್ಕಾರಕ್ಕೆ ಎಚ್ಚರಿಸೋಣ.

ರಾಷ್ಟ್ರಪಿತನ ಹುಟ್ಟುಹಬ್ಬವಾದ ಅಕ್ಟೋಬರ್ 2 ರಂದು ಗಾಂಧಿ ಪ್ರತಿಮೆಯ ಎದುರು, ಬೆಳಗ್ಗೆ 10 ರಿಂದ 4 ರವರೆಗೆ ಉಪವಾಸ ಧರಣಿಯಲ್ಲಿ ಭಾಗವಹಿಸಿ.

ಮಹಿಳಾ ಪ್ರಗತಿ ಮತ್ತು ಮಹಿಳಾ ಸಂಸ್ಥೆಗಳು.

goods - public health and the environment, for instance - the behaviour of the tobacco industry came up again. Several participants had expressed concern about the possible exclusion of people from the developing world in the exercise because of their lack of access to the Internet. Therefore, several participants argued that efforts to set up such global public policy networks must ensure 'inclusion' to the maximum extent possible.

The lone voice demanding the right to exclude came from a representative of WHO. The organisation is in the process of developing an international treaty to regulate the promotion of cigarette marketing. And it has consciously decided to exclude the tobacco industry from its deliberations. The industry has no moral right left to demand participation after its past behaviour, contended the WHO official. A rare position for an international bureaucrat to take in a world increasingly dominated by private interests. "If you don't believe me, then go and see the new movie, The Insider," he said. In fact, the whistleblower, Jeffrey Wigand, former scientist of Brown and Williamson, one of USA's top cigarette manufacturers, is today an important participant in the WHO negotiations.

We, therefore, decided to go off and see the movie. The movie had a powerful impact on us. After Wigand decided to tell the world about the research he had been asked to undertake which increased the addictive effect of nicotine, and thus contradict the public statement made by the company's CEO to the US Congress, the company did everything to keep him quiet. The company fired him but with a confidentiality agreement that threatened to destroy him financially. With a child suffering from acute asthma, Wigand could not lose his medical insurance cover. When the producer of 60 Minutes, an investigative programme of CBS, discovered Wigand, he had to go through a long, protracted process to get Wigand to agree. Wigand agreed but CBS then faced the threat of violating the confidentiality agreement and facing a major lawsuit.

The TV producer got Wigand to first give testimony in an anti-tobacco court case, a process that lies outside confidentiality agreements. In the resulting tension exacerbated by prowlers stalking Wigand's family, presumably sponsored by the company to frighten him, Wigand's wife decided to leave him. But even after all this, corporate lawyers at CBS stopped the telecast of the programme. They feared that a lawsuit against damages would reduce the stock value of CBS to a point that Brown and Williamson could take it over.

The film reaches a frightening point when the power of money literally seems to take over the power of the media - in fact, the very power of democracy - and leave Wigand and the TV producer high and dry, without any friends and support. Finally, the producer decides to risk his job and leaks the story of how CBS has held up the 60 Minutes telecast to The New York Times. With the cat out of the bag, CBS finally decided to air the programme.

What amazed us is the parallel that the entire story had with the Indian auto giant TELCO's effort to frighten us in our campaign against diesel with a Rs 100 crore legal notice. The idea clearly was to tell us that by taking up such issues we would run the risk of financial ruin. It appears that in the age of the Internet and globalisation, Indian companies are learning faster from their Western counterparts on how to fight the civil society and the media than how to protect public health and the environment.

- Anil Agarwal

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MH-2.

Globalization and Increasing Trend of Alcoholism *

1. Introduction

Although alcohol consumption has existed in India for many centuries, the quantity patterns of use, and resultant problems have undergone substantial changes over the past two decades. Alcohol consumption produces individual health and social problems. The global burden of disease from alcohol exceeds that of tobacco and is on a par with the burden attributable to unsafe sex world wide (Global Status Report on alcohol, WHO, 1999). Although recorded alcohol consumption per capita has fallen since 1980 in most developed countries, it has risen steadily in developing countries and alarmingly so in India. The per capita consumption of alcohol by adults of 15 years and above in India increased by 106.67 percent between 1970-72 and 1994-96!

2. Alcohol industry

Based on beverage type the Indian alcohol industry has three prominent sectors: The IMFL (Indian Made Foreign Liquor) and beer sector, the country liquor sector, and the illicit liquor sector. The IMFL and beer sector is the most visible part of the alcohol Industry, with a few large companies with multiple production units and nation wide marketing networks. These companies control much of the market. They have been present in India for several decades and have established several brand names regionally or nationally. These companies aggressively advertise and promote their brands and their corporate identities, and constantly monitor and protect their products and market shares. They are also cash rich, since profit margins are high in this industry.

Beginning in 1992 under liberalized industrial laws, some Indian alcohol companies developed collaborative ties with international corporations. Joint ventures have been established to use local production capacity to manufacture international brands under a technology transfer and licensing system. These joint ventures have served a dual purpose: they have brought international alcohol brands to India, and they have utilized the existing production and marketing strengths of Indian Industry. Hence they have been mutually supportive. Nearly all of the major transnational alcohol companies now have a presence in India and many internationally popular brands of whisky and beer have become available. The upper middle and higher socioeconomic classes now purchase these 'famous' brands locally rather than having to carry these back from trips to other countries or to buy them from illegal importers. The price of these products remains high, but since they carry high social prestige value, there is good demand in this premium range.

With liberalization and globalization, foreign liquor has become freely available. The IMFL and beer industry spends much effort and money to promote and advertise their brands. Since direct advertisement of liquor was
not permitted in the print and electronic media, the industry has found methods to advertise indirectly (Saxena, 1994). Alcohol brands are advertised in the form of same or similarly named other products (e.g. mineral water, soda, and playing cards) made by the same company. The advertisements

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Compiled by Mr. S D Rajendran, Community Health Cell for the Asia Social Forum, 2nd – 7th January 2003, Hyderabad, India.

display the alcohol product prominently. In addition, beverage ads have become common on satellite cable television beamed to India from neighboring countries. IMFL and beer producers also financially sponsor major sporting events that attract sustained media attention, including live television coverage of the event. With its new international linkages, the Indian alcohol industry has also got into the entertainment and fashion world. It is now common for a liquor company to sponsor a fashion show or musical event. Hence the Indian IMFL and beer industry has initiated a high level of sustained marketing and promotional activities and these have become especially aggressive in the 1990s.

The Indian alcohol industry produces a large amount of revenue for the government. It has been estimated that direct collections of excise and sales tax are approximately US$ 5 billion per year for the country as a whole. In Karnataka, it is approximately Rs. 2400.00 crores per year. States derive as much as 25% of money from alcohol sales for their annual budget. Besides the generation of legal revenues for the government, the alcohol industry is thought to create an approximately equal sum in "black money" that takes the form of bribes, protection payments and profits from illicit alcohol. This gives the alcohol industry enormous political power and clout, which may be used to help influence and maintain government policies 'beneficial' to the industry but harmful to the people. Studies indicate that the losses borne by household, states and the nation out weigh financial gains.

Table 1: Annual Distilled Spirits Production in India, by Year (April to March)

Year	AMOUNT OF ABSOLUTE ALCOHOL PRODUCED (IN THOUSANDS HECTOLIRES)
1982 – 83	2862.55
1983-84	3104.75
1984—85	3310.64
1985-86	3407.49
1986-87	3204.80
1987-88	3432.48
1988-89	4190.45
1989-90	No data available
1990-91	No data available
1991-92	4895.00
1992-93	3467.00
1993-94	3626.00
1994-95	6056.00
1995-96	7888.04

Source: Alcohol and Public Health in 8 developing countries, WHO, Geneva, 1999.

3. Alcohol – Related Problems

It is probable, given equal amounts of drinking, that developing countries like India experience more problems than developed countries (Saxena, 1997). Among the reasons for this may be such things as a highly skewed distribution of drinkers in the society, the prevalence of nutritional and infectious diseases, economic deprivation, more hazardous and accident-prone physical environments, and lack of any organised support system. Although conclusive scientific evidence for alcohol related health and social problems is lacking for India, there are enough

indications in the available literature to infer that these are substantial. Women's sanghas participating in a women health empowerment training in several districts in Karnataka have consistently said that the biggest problem they face relate to alcohol abuse. Community health groups in different parts of the country also recognize the importance of the problem. The rapid rise in alcohol consumption in recent years has increased the likelihood of further growth of the following health problems in the years to come.

3.1 Health problems include

- Cirrhosis of the liver and premature death
- Cardiomyopathy
- Cancer of the upper gastrointestinal tract
- Pancreatitis
- Cognitive impairment or neuropsychiatric disorders
- Road traffic accidents and injuries
- Nutritional deficiencies and infections
- HIV infections and STD
- Hypertension

3.2 SOCIAL PROBLEMS

Excessive drinking produces a variety of closely inter related social problems in India. For ease of description these have been divided into the following broad categories.

3.2.1 *Violence and Crime*

Violence within and outside the home is frequent in India and a substantial proportion of it is alcohol – related. Wife beating and child abuse under the influence of alcohol are common, and street brawls and group violence happen often after drinking

3.2.2 *Workplace effects*

Heavy drinking affects work performance in a number of negative ways. When compared to their sober counterparts, drinkers are more frequently absent, are less efficient, have more accidents at work, and also show maladjustment with other workers which leads to over all decreased performance.

3.2.3 *Economic Effects*

While alcoholic beverages are less expensive in India, their purchase may still require a substantial portion of a poor persons meager income. With one in three people in India falling below the poverty line, the economic consequences of expenditures on alcohol attain special significance. Besides money spent on alcohol, a heavy drinker also suffers other adverse economic effects. These include reduced wages (because of missed work and lowered efficiency on the job), increased medical expanses for illness and accidents, legal cost of drink-related offences, and decreased eligibility of loans. Most individuals with severe alcohol dependence find it difficult to reduce their expenditure on drink, and hence their families often must do without essential necessities. Although the overall economic

effect of alcohol use at the national level has not been estimated, it is likely that it represents a substantial proportion of India's national income.

3.2.4 *Family Effects*

Excessive drinking by one or more family member results in several negative consequences for others in the family, especially for the wife and children of a male drinker. These effects are particularly serious for poor families. As has been mentioned above, much of the family income may be used to buy alcohol, wages may decline, and the drinker may eventually lose his job. In such situation the wife and children are forced into work, often in low paid, hazardous jobs. Children may be unable to continue their schooling and may also suffer from nutritional deficiencies because there is not enough to eat at home. Wife and child battering are common, which lead to physical and mental trauma. Failure of the man to use contraceptive methods often leads to unwanted pregnancies, further increasing family size. These factors contribute towards greater poverty, often to the point of destitution.

Strong family ties and social disapproval of divorce save many of these families from a formal breakdown, but the prevalence of intermittent or prolonged marital separation, as well as suicide, in heavy drinking families is high. Problems faced by wives of alcoholic men have been studied scientifically by Ganihat et al. (1983), but the many descriptive accounts by the lay press offer more vocal testimony of these phenomena. Wives of alcoholic men show a high degree of depression (Devar et al., 1983) and of suicide (Ponnudurai & Jayakar, 1980)

4. Govt. of India Response

Govt. of India should seriously think about the alarmingly increasing alcohol related problems and work towards developing a clear-cut and comprehensive Alcohol Policy.

The Indian Charter on Alcohol should be adopted with the following principles, which would be agreed upon by all the health ministries of the States:

1. **All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.**

2. **All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.**

3. **All the children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.**

4. **All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.**

5. **All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non – drinking behavior.**

5. National Master Plan

The government of India formed an expert committee in 1986 to develop a comprehensive strategy for reduction of both supply and demand of all substances of abuse, including alcohol. The details of the master plan and its position on alcohol – related issues are not yet available. Again Govt. of India should review the National Master Plan and revise it for up to date condition. This plan should be implemented through Primary Health Centres and through health workers. It should contain the following broad areas:

1. Training to PHC doctors and Health Workers
2. Raise awareness of the effects of alcohol in rural areas
3. Arrange community based de-addiction treatment involving family members and the community
4. Proper after care should be provided with the family and community support
5. Introduce Life Skills programme in high schools to increase the ability of young people to meet the needs and challenges of every day life and avoid high risk behaviors
6. Provide and / or expand meaningful alternatives to alcohol and drug use and increase education, training and networking among community development workers and organisations.

In monitoring and implementing the above plan, the local NGOs and community action groups should be encouraged to participate fully.

6. Conclusion

Globalisation is based on commercial interests, which want to increase the consumption of alcohol. They promote the expansion of drinking into new social context and situations. Their central perspective is that of the market, seeing developing countries as 'emerging markets'. Drinking is shown as a symbol of 'cosmopolitan outlook'. European and North American life styles are presented glamorously and attractively. We have to counter them. Globalisation has brought in global methods of manufacture, distribution, advertisements and promotion of alcohol consumption. We have to adopt or adopt global strategies to reduce alcohol consumption and its ill effects on the health and social life of our people. While interventions for primary prevention and community health based approaches are required along side medical deaddiction approaches, it is imperative that social movements also address the broader policy aspects and economic underpinnings of the problem.

Since the BMA [illegible] there has been a decrease in the popularity of alcopops and a number of developments have occurred including a commitment by Government to develop an alcohol strategy as mentioned in the Government's, *Our Healthier Nation* strategy. A Ministerial Group on Alcopops was also set up in 1997. This Group published a second progress report in November 1998 outlining action taken to reduce the incidence of under-age alcohol misuse. These measures included two million pounds funding for educational programmes and legislative changes involving confiscation of alcohol from children drinking in public and the closure of a loophole in the law which prevents employees of big retail chains being prosecuted from selling alcohol to underage people. They did not however recommend a change to the voluntary arrangement which currently exists regarding the monitoring of the drinks industry.

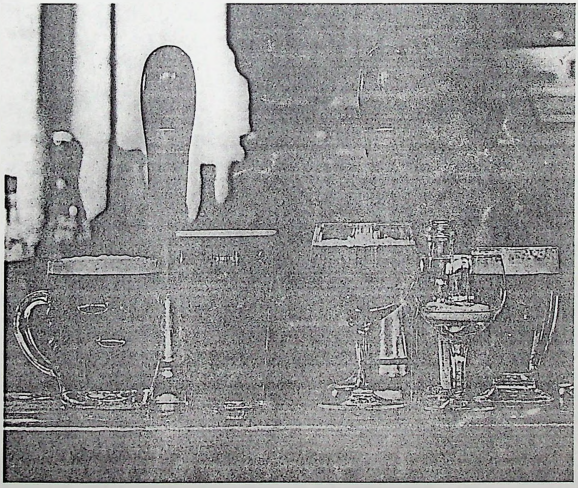
Education and enforcement

Control and prevention through legislation, however, are not the only consideration as early exposure to and consumption of alcohol takes place in the home environment[8] and although some alcohol may be purchased by the underage drinkers themselves, it can also be bought for them. Availability of alcohol and peer influence has an impact on consumption and the BMA supports interventions, especially education programmes to help young people develop sensible attitudes to drinking, and provide information on the short term risks of acute alcohol intoxication and longer term effects of problem drinking. All young women and intending parents should be made aware of the dangers of alcohol consumption to the fetus particularly in the early weeks of pregnancy. High levels of consumption in pregnancy are associated with Fetal Alcohol Syndrome.

There is a statutory requirement under the National Curriculum Science Order to cover certain aspects of drug education in schools. At Key Stage 2 (7-11 years) pupils should be taught that "tobacco, alcohol and other drugs can have harmful effects"; at Key Stage 3 (11-14 years) they should be taught that "the abuse of alcohol, solvents, tobacco and other drugs affect health...." and at Key Stage 4 (14-16 years) they should be taught "the key effects of solvents, tobacco, alcohol and other drugs on body functions". Circular 4/95, *Drug Prevention and Schools*, whilst promising to "focus on tobacco, alcohol and volatile substances in addition to illegal drugs", it fails to adequately address the issue of alcohol and young people.[9]

BRITISH MEDICAL ASSOCIATION
Board of Science and Education

Alcohol and young people



BMA

A publication from the BMA Science Department

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Contents

Scope and background

The British Medical Association has developed comprehensive policy addressing the issues surrounding alcohol use and the problems which can arise from its misuse, in terms of the effect on the individual and society in general. More recently the following resolution was adopted as BMA policy at the 1996 BMA Annual Representative Meeting (ARM):

That this Meeting is concerned that unacceptable levels of alcohol are present in some of the drinks which are aimed at the teenage market and believes that the deliberate targeting of this group by purveyors of alcohol should be made illegal.

Among the issues lying behind this resolution are:-

- Recent studies indicate a rise in the proportion of young people (11-15 years) who drink regularly, and an increase in the amount they are drinking on each occasion.[1]
- The appeal of 'designer drinks' is at its height between the ages of 13-16 years.[2,3]
- The BMA is concerned that unhealthy patterns of drinking by teenagers may lead to an increased level of addiction and dependence on alcohol in adulthood.[4]
- Teenagers are more likely to have casual sex and are less likely to use condoms when under the influence of drugs or alcohol.[5] Such risk taking may result in unwanted pregnancies and sexually transmitted diseases.

Such trends are worrying as alcohol consumption, in particular both regular heavy consumption and 'binge drinking', has been associated with physical and mental health problems, antisocial behaviour, domestic violence, accidents, and injuries. Drinking too much on a regular basis will increase the risk of damaging ones health, ie liver damage, mouth and throat cancer, raised blood pressure. 'Binge drinking' is a particular risk for young people as alcohol may have more of an effect on them, compared to older drinkers.

There is a need for government action to address the problems of underage and teenage drinking. This must involve changes to legislation, responsible marketing, effective monitoring of the drinks industry and health education. This paper raises a number of issues for consideration by government and the drinks industry which are specifically related to the 1996 ARM resolution, ie the problem of designer drinks aimed at young people, principally those under 18 years old.

Designer drinks

During the nineties, new ranges of alcoholic drinks, often referred to as designer drinks, were introduced into the market. These included fruit flavoured wine and spirit based drinks, strong white ciders and alcoholic 'soft drinks', ie alcoholic lemonades, sodas, and cola which are often referred to as 'alcopops'; the latter were introduced in 1995. There has been significant debate on the potential appeal of these drinks to young people and whether they have had any influence on alcohol consumption. Evidence suggests that the consumption of these drinks is associated with heavier drinking in less controlled environments[5] and therefore likely to pose a greater health risk.

Primarily because of their sweet taste and image, many teenagers find that designer drinks taste less obviously of alcohol, compared to the more traditional drinks of equivalent strength.[6] The fact that the alcohol flavour is masked by the sweetness of the drink may lead to an underestimation of the strength, resulting in greater levels of intoxication. Concern has also been expressed about the alcoholic content of such drinks since some of them are stronger than the more traditional drinks. (See **Table 1**)

Designer drinks	**Alcohol by volume (ABV)**
Alcoholic lemonades and colas (eg *Two Dogs, Hoopers Hooch*)	3.5% - 5.5%
Strong fruit flavoured wine based drinks (eg *MD 20/20, Thunderbird*)	13% - 13.5%
Cooler/mixer/blender type drinks (eg *Bacardi Breezer, Castaway*)	4% - 6%
Super-strength ciders (eg *Diamond White*)	6.5% - 9%
Traditional drinks	
Beer/lager/cider	3% - 6%
Super-strength lagers	8% - 9%
Wines	9% - 13.5%
Spirit based mixtures	14.5% - 25%
Spirits	37.5% - 43%

Table 1: Alcoholic content of drinks. Source: *Young People and Alcohol* - Health Education Authority 1996.

Marketing

There is concern that these drinks have been marketed to appeal to young people, particularly those who are not legally permitted to purchase them. In the *Survey of attitudes and behaviour towards new types of alcoholic drinks in England 1996*, undertaken by the Health Education Authority, respondents were shown photographs of different drinks and, contrasting alcopops with ordinary beer, lager and cider, 11-18 year olds saw alcopops as more refreshing, better tasting, less likely to taste of alcohol and 'trendier'.[6] There is then the question of whether by appealing to young people, designer drinks are to some extent legitimising underage drinking. Surveys have shown that the level of consumption of designer drinks peaks around the ages 13-16, suggesting that they are attractive to this age group.[2,3]

Designer drinks and alcopops are likely to have some appeal to young people due to the marketing images, labelling style and names given to the drinks. In addition to legislation designed to reduce availability and the promotion of education programmes, marketing is an area which warrants special consideration; price, strength and taste are also factors taken into account in the choice of drink. Further evidence is needed to determine whether the new designer drinks and alcopops have encouraged more young people to start and continue drinking as they get older, or have encouraged greater consumption and whether these drinks act as 'gateways' to more traditional drinks. The BMA would support the calls for further research to ensure their impact is monitored.

Whilst some of the new drinks are stronger than traditional drinks they are not necessarily the only drinks consumed by young people. Lager and cider are often the most popular drinks (See Figure 1), with alcopops preferred by the more occasional drinkers. The BMA believes that problems associated with alcohol consumption and misuse are not confined to the new drinks and alcopops alone. Very few young people drink only alcopops.[1] Banning them would be difficult and fail to address the wider problem. However, there are measures which can be considered to address the concerns relating to the marketing of designer drinks and alcopops in particular.

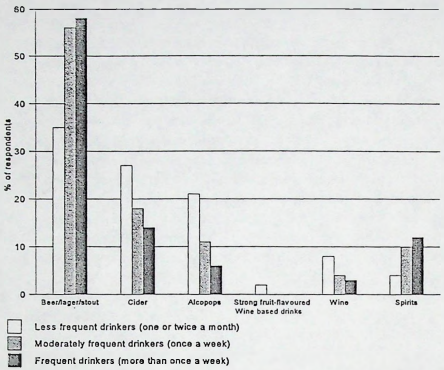

Figure 1: Type of alcoholic drink consumed most often by respondents aged 13-16 years, according to frequency of consumption (Base: all respondents who drink alcohol at least once or twice a month, aged 13-16 (337 respondents) - results from a Health Education Authority survey of a nationally representative sample of 1543, 11-18 year olds). Source: *Young People and Alcohol* - Health Education Authority 1996.

Monitoring of the drinks industry

Complaints can be submitted to the Portman Group under the voluntary Code of Practice on "the naming, packaging and merchandising of alcoholic drinks" which was launched in 1996 and updated in 1997. Complaints can also be made about a retailer if it is considered that not enough care is being taken to ensure alcoholic drinks are sold to adults only. The Portman Group has no regulatory powers over retailers or manufacturers. At present a complaint can be made to an Independent Complaints Panel convened by the Portman Group about any drink which exceeds 0.5% abv if it is considered that the name, packaging or merchandising of the product:-

- is more likely to appeal to under 18s than to adults;
- suggests any confusion as to the product's alcoholic nature or strength, or glamorises its alcoholic strength;
- links the product to illicit drugs or to dangerous or antisocial behaviour, or encourages irresponsible consumption;
- suggests sexual success or prowess.

Recommendations

- An independent proactive regulator with powers of enforcement should be introduced to review complaints regarding manufacturers of alcohol and marketing practices, replacing the voluntary arrangement which currently exists with the Portman Group Code of Practice.
- The criteria for assessment of complaints about alcoholic drink products (see Page 4) is supported, together with powers for an independent regulator to vet alcoholic products before they are launched and withdraw products which don't comply with the criteria.
- The advertising code on alcohol should be subject to greater enforcement by the Independent Television Commission and the Advertising Standards Authority, particularly with regard to young people and should include more rigorous controls on sports sponsorship and cinema advertising.
- The ruling in Scotland where it is an offence for anyone over 18 years of age to buy alcohol for a person under 18 years of age for public, unsupervised consumption should be extended to the rest of the UK and the existing licensing legislation be reviewed for consistency.
- A change in legislation to allow test purchases by under 18s working with designated enforcement authorities in precise and controlled circumstances is supported. It would enable more effective enforcement and would have a major impact in reducing this source of access to alcohol by children.
- The BMA encourages the responsible sale of alcohol by all types of retailers including off-licences, supermarkets and garages and supports compulsory training programmes for licensees as a condition of receiving a licence on the legislation relating to young people and alcohol and in dealing with underage or intoxicated customers.
- The BMA supports voluntary initiatives to enable young people to prove their age, subject to appropriate ethical considerations, thereby curbing underage purchasing of alcohol and assisting licensees.
- The BMA believes that it is the responsibility of the drinks industry, both producers and retailers, to ensure that their customers are fully aware of the alcoholic content of the beverages they purchase and the potential harmful consequences of excess consumption. Retailers should be required to publicise information about the strength of drinks and clarify the definition of a 'unit' of alcohol at the point of sale.

- There should be a legal requirement for all containers of alcohol offered for sale and advertisements to carry; a prominent common standard label which clearly outlines the alcohol content in terms of units (clearly defining the meaning of a unit of alcohol, 8g of alcohol per unit = approximately 1 small glass of wine, ½ pint ordinary strength beer, lager or cider, single measure of spirits); information on the maximum recommended daily level of alcohol consumption and; a warning of the dangers of 'excessive' drinking.
- The BMA supports the calls from other organisations for increased alcohol education to be introduced into schools starting at primary level which should be formalised by means of specific alcohol guidance from the Department for Education and Employment (DfEE). Alcohol should therefore not be included within drugs education as at present, but should be dealt with as a separate topic.
- Alcohol education should be available as a compulsory curriculum module for training teachers, occupational health workers and medical students.

The BMA supports the crite[illegible] th[illegible] Complaints, however, in order to be certain that drinks are not produced and marketed to appeal to the underage drinker, the Association believes that a number of changes need to be made, in particular with regard to the independence of the monitoring body and legislative powers required to undertake enforcement. At present the Independent Complaints Panel considers complaints and reports submitted by organisations such as Alcohol Concern and the Health Education Authority. Fifty out of 87 complaints submitted up to January 1998 were upheld.[7] A proactive independent monitoring body with regulatory powers and dedicated resources throughout the country could undertake this role more effectively than a self regulated one, operated at present by the Portman Group. Complaints at present are only able to be made about products already in production and available for sale and, consideration should be given to a regulatory system at the pre- production and marketing stage.

Currently, complaints about advertisements for alcoholic drinks can be submitted to the Advertising Standards Authority who monitor advertising codes. The codes on alcohol should prevent the suggestion that drinking enhances sporting prowess, although sports sponsorship by drinks companies is commonplace. The BMA is particularly concerned about advertising which is specifically targeted towards the young and which links alcohol with illicit drug use, by use of symbols of youth culture. The Portman Group recently ruled against a producer for using marijuana leaves on a drinks label. Cinema is another area which is under regulated with children often exposed to alcohol advertising during screenings of films for under 18s.

Current legislation

The main regulations relating to young people and alcohol are set out in the 1964 Licensing Act for England and Wales, The Licensing (Scotland) Act 1976 and Licensing (Northern Ireland) Order 1996.

It is illegal for somebody under 18 to buy alcohol and it is illegal to sell alcohol to somebody under 18 other than in the following circumstances:- (See Table 2)

Under 5 years of age	Illegal to give alcohol to a child, except with permission from a doctor or in a medical emergency.
Under 14 years of age	Not allowed in to a bar during opening hours unless the bar has a children's certificate. At the discretion of the licensee, allowed in other parts of the licensed premises but not allowed to buy or be bought or consume alcohol. May consume alcohol at home.
Aged 14 and 15 years	Allowed in a bar at the licensee's discretion but not allowed to buy or consume alcohol. May consume alcohol at home.
Aged 16 and 17 years	In England, Wales and Scotland, allowed to buy or be bought certain drinks but only in separate eating area and as an accompaniment to a meal. Permitted drinks are beer and cider in England and Wales. The law in Scotland also includes the purchase of wine. May consume alcohol at home.

Table 2: Laws relating to the purchase and consumption of alcohol in respect of persons under 18 years of age.

In England, Wales and Scotland, the police are allowed to confiscate alcohol from persons under 18 years of age found drinking in public places and are also allowed to confiscate alcohol if they have reason to believe that the alcohol is to be consumed by individuals under 18 years of age. In Scotland it is an offence for anyone over 18 to buy alcohol for a person under 18 to be consumed in public, unsupervised, and the BMA believes that this should be extended to the rest of the UK.

The use of test purchasing to detect underage sales practice in both on and off-licences is supported. Current legislation allows for the practice with regards to tobacco but not alcohol.

Current legislation has remained virtually unchanged for over 30 years and there are a number of anomalies (some of which relate to different parts of the UK). For example, a 16 year old cannot purchase alcohol or consume it in the street, but is allowed to have certain drinks, eg beer and cider with a meal on licensed premises. At 16, young people are prohibited from buying alcohol but are old enough to marry, join the armed forces, engage in sexual intercourse, purchase tobacco and at 17, drive a car. This sends a confused message to the young as do the current marketing strategies relating to designer drinks. A Government review of existing licensing legislation with a view to introducing consistent legislation is to be welcomed.

Since the BMA [illegible] there has been a decrease in the popularity of alcopops and a number of developments have occurred including a commitment by Government to develop an alcohol strategy as mentioned in the Government's, *Our Healthier Nation* strategy. A Ministerial Group on Alcopops was also set up in 1997. This Group published a second progress report in November 1998 outlining action taken to reduce the incidence of under-age alcohol misuse. These measures included two million pounds funding for educational programmes and legislative changes involving confiscation of alcohol from children drinking in public and the closure of a loophole in the law which prevents employees of big retail chains being prosecuted from selling alcohol to underage people. They did not however recommend a change to the voluntary arrangement which currently exists regarding the monitoring of the drinks industry.

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Control and prevention through legislation, however, are not the only consideration as early exposure to and consumption of alcohol takes place in the home environment[8] and although some alcohol may be purchased by the underage drinkers themselves, it can also be bought for them. Availability of alcohol and peer influence has an impact on consumption and the BMA supports interventions, especially education programmes to help young people develop sensible attitudes to drinking, and provide information on the short term risks of acute alcohol intoxication and longer term effects of problem drinking. All young women and intending parents should be made aware of the dangers of alcohol consumption to the fetus particularly in the early weeks of pregnancy. High levels of consumption in pregnancy are associated with Fetal Alcohol Syndrome.

There is a statutory requirement under the National Curriculum Science Order to cover certain aspects of drug education in schools. At Key Stage 2 (7-11 years) pupils should be taught that "tobacco, alcohol and other drugs can have harmful effects"; at Key Stage 3 (11-14 years) they should be taught that "the abuse of alcohol, solvents, tobacco and other drugs affect health...." and at Key Stage 4 (14-16 years) they should be taught "the key effects of solvents, tobacco, alcohol and other drugs on body functions". Circular 4/95, *Drug Prevention and Schools*, whilst promising to "focus on tobacco, alcohol and volatile substances in addition to illegal drugs", it fails to adequately address the issue of alcohol and young people.[9]

Industry and government have a responsibility to promote and enforce the legislation relating to alcohol purchase and consumption and publicise the 'sensible drinking message' as widely as possible. The BMA, as far back as the 1986 Annual Representative Meeting, resolved to *"support a policy of sensible drinking of alcohol, recognised that a total ban on alcohol advertising was impracticable, and urged government to require a health warning against excessive alcohol consumption to be incorporated into alcohol advertisements"*. Extending this view, the BMA believes that a common labelling standard for alcohol units should be developed and clearly displayed on products and also in advertisements, together with the existing BMA sensible drinking guidance, ie (2 units per day for women and 3 units per day for men).

Evidence suggests that off-licences are the most common place of purchase of alcohol by 11-16 year olds.[6] Many supermarkets and garages, often now open 24 hours a day sell alcohol. Not all staff may be aware of, or may pay less heed to the legislation, regarding the sale of alcohol to young people. Retailers of alcohol have a key role to play in the enforcement of legislation and in reducing the incidence of underage drinking and also 'binge' drinking. Staff training programmes and the wider use and promotion of voluntary ID cards are positive measures to assist licensees and retailers. Consideration should also be given to more punitive measures of test purchasing, point of sale advertising restrictions, and legislation to make it illegal for those over 18 to purchase alcohol for under 18s.

Conclusion

The problem of underage drinking and teenage alcohol consumption should be viewed not just in terms of drinks aimed at the teenage market but also in relation to issues concerning education, access to alcohol and regulatory enforcement. Issues relating to the culture in which young people are growing up and the example set by adults are also important.

The BMA welcomes the research, education and other initiatives undertaken in recent years by some key organisations working in this field including the Health Education Authority, Alcohol Concern and the Portman Group. The Ministerial Group on Alcopops has made progress, however, with such a large group of vulnerable young people involved, more effective action could have been proposed in their 1998 review.

Chapter - IX
Youth Health, Drug Abuse, Alcohol and AIDS

YOUTH HEALTH, DRUG ABUSE, ALCOHOL AND AIDS

Introduction:

In view of the increasing importance assigned to young people in terms of the size of this segment of youth population (25-20% of the whole population of the world), the role in shaping the present and future of humanity is in their hands. Therefore it is very essential to take appropriate steps for their health care and development. There is a growing concern all over the world to develop plans for their betterment. It is all the more important for India to take measures for this growing population which is 25% at present and will be most 30% by the turn of the century. It has been estimated that in absolute numbers, the youth and adolescent would be 370 million Adolescents, particularly in India, are the selective survival group because of high infant and child mortality rate. In one report, 50% of children do not survive to celebrate their fifteenth birthday. Hence they become very precious for the family, community, and nation at large. It is encouraging that in recent years there is a declining trend in infant mortality and child mortality because of improvement in health care programmes for children. So it is expected that in the coming years the adolescent population would increase. On the other hand for many reasons this segment of population remains unattended for their growing biological and psychological needs because of poverty, illiteracy, and ignorance. Hence the present adolescents and youth are disgruntled and in conflict with the adults. Other factors like modernization, urbanization, and industrialization are giving them a new direction– to leave their traditional values without establishing new values and new skills to cope with the changing scenario. Thus they are put into another kind of emotional and social stress, dragging them to delinquency, crime, violence, and drug abuse. There is a change in the moral codes and value systems, changing their ethics, morals, and sexual conduct. Youth Health per se cannot be discussed in isolation as a medical specialty along. The other influencing factors, aspects and issues related to health at large should be given serious consideration. Hence it is extremely important to involve experts in the fields of medical and allied sciences, the media, administration and policy planning.

Health has been recognized as a basic human right in the UN. At the same time infectious diseases have already cost millions of lives most of which are in the vital age group, more specifically, the school going child and working age youth who are the potential work forse of today and tomorrow. Despite public health interventions, the mortality rates are on the rise in the country, providing fertile grounds for spread of infections. Seventy percent of young people between 25 to 40 years succumbed to adverse health conditions. Today, the young people are themselves becoming targets of a host of biological and psychosomatic ailments

and misdirected lifestyles. It is, therefore, necessary to develop and promote a series of alternative economically low cost and viable life styles.

Incidences reproductive health risks and consequences such as unwanted and teenage pregnancies, abortions, rape, STD etc. associated with youth behaviour are on the rise. The maximum youth of 15 to 24 years of age group were prone to STD infection. Further, the changing family and disintegration of community ties and social control system had led to delingernt behaviour among youth. Social studies, here shown that there was a rapid increase in pre-marital sex and rising trend ain teenage preganancies. 40 per cent of women reported for abortions were unwed girls under the age of 20 and also an increasing sex related high risk behaviour among college and university students. Citing a survey made by Family Planning Association of India (FPAI) in 16 cities, he said that 23 per cent of young within 15 to 29 years of age were educated and unmarried and 20 per cent young men and 10 per cent young women did not consider pre-marital sex to be shameful. 90 per cent of young women as against 77 per cent of men did not consider pre-martial sex as wrong. Another study of students of Hyderabad showed that sex indulgence in rural areas was more than urban areas as against the popular view that rural folk indulged less in sex than their urban counterpart. It was important for the health planners to cover the rural areas rather than limiting interventions in the urban sector. Every year about 3 million girls got married within age of 15 to 19 years and more than 1 thousand women died from child bearing. The Government had been emphasising on child and infant mortality while youth mortality had been totally a neglected sector.

Intervention programmes needed for consideration :

(I) convergence of youth planning and health planning, (ii) appropriate educational curriculum and information on STDs and reproductive health both in formal and non-formal settings, (iii) youth programmes managers to understand knowledge, beliefs, values and practices associated with diseases and its prevention, (iv) proper training to STD patients to advocate health sexual behaviour, (v) promoting healthy habits and personal sexual hygiene, (vi) enhance individual behaviour relating to primary and secondary prevention of behaviour , (vii) develop health action model on the basis of WHO recommendations, (Viii) use of non-traditional methods in programme planning, (ix) Promoting mass and folk media along with appropriate health promotion education, (x) holiness in youth friendly organisations, (xi) schools and colleges as potential primary preventive agencies, (xii) imaginative outreach programmes, and, (xiii) counseling and prevention centres through NGOs and youth clubs/organisations.

For preparing and empowering the youth for the twenty-first Century, The ministry of Human Resource Development, Govt.of India has identified the few

areas concerning strategies to deal with the problems and health needs of adolescents and youth as follows:-

1. General Health
   - Reproductive health and Sexual Health
2. AIDS and Sexually Transmitted Diseases.
3. Crime, Delinquency, Drug Abuse, Alcoholism, Use of Tobacco related health problems and Violence.
4. Social and Medical support mechanisms for Adolescents and Youth in the current Scenario.
5. To review the strengths and gaps in the current health programmes
6. Strategies for the future.

World Health Organisation defines adolescence as between the ages of 10 and 19 years (the second decade of life). Adolescents constitute about one-fifth of the people in the world which means more than 1 billion persons. In India adolescents constitute 22.5% of the population, or nearly 210 million in 1996. While chronological definitions are necessary for statistics and comparison, there is great variation in the onset of changes that herald adolescence and culminate in adulthood.

Adolescence is a crucial and dynamic time in the lives of young people. It is a time when young people develop their capacity for empathy with others, for abstract thinking, and for looking ahead; a time when close and dependent relationships with parents begin to give way to more intense relationship with peers. The chief task of adolescence is to acquire a sense of identity.

The growing capabilities of young people re simply the raw materials of human development. The increased capability of adolescence and youth do not guarantee that healthy development would take place. That depends upon other factors at home and the community, and the mix of support and opportunity provided by adults. The way they have been loved, valued and educated, and the injustices and discrimination they had to face.

Who defines Youth as between 15 and 24 yrs. In India Youth apparently lasts longer. According to the Dept.of Youth Affairs, Ministry of HRD, youth lasts from 15 to 35 years. According to this definition, about 32% of India's population (270 million in 1991 census) is constituted by Youth.

Youthhood constitute a period of transition, when the young people try hard to make a place for themselves in the world. It is the period of new challenges, new opportunities, and new responsibilities. Appropriately, the National Youth Policy (1988) lay strews on the mass education of youth, alongwith skill development

for self employment. Now we'll take a brief look at the health needs and health problems peculiar to adolescents and youth.

In addition to the general health problems of youth the following issues will get serious consideration in a perspective plan upto 2020 AD.

- Accidents and Injuries
- Disablities
- Changing emotional behaviour
- Changing scenario of sexual behaviour
- Impact of educational systems and media on their health.
- Employment and career.

Some of the salient issues related to youth are outlined below:

1. NUTRITION

Adolescents need food not only for their abundant activities, but also for growth. The nutritional status of adolescents is usually measured in terms of weight for height expressed as Body Mass Index (BMI), a better indicator of health status of adolescents than weight-for-age because of wide variation in rates of development. The data that is available indicate that the average BMI among 11-18 year olds is considerably lower in the developing countries as compared to industrialized countries (WHO,1993).

Iron deficiency anemia is another common condition, especially in girls, who need 10% more iron as a result of menstrual loss. Furthermore, the growth related needs of adolescents continue into the early twenties and will overlap with nutritional requirements generated by pregnancy. Iron needs in adolescent girls may be further complicated by diseases such as malaria and hookworm. Discriminatory practices against the girls also lead to lack of adequate intake which may lead to protein energy malnutrition, anemia and other micronutrient deficiencies in the young girls.

Eating disorders, essentially of psychogenic origin, such as anorexia nervosa and anemia, are also a problem, especially with urban girls and youth victims of violence in rural, urban and tribal areas that may threaten their nutritional status. Mention may also be made of the increasing risk of obesity due to decreased physical activity and increasing use of junk food among adolescents.

2. SEXUALITY AND REPRODUCTIVE HEALTH

All young people experience puberty and go through physical and psychological changes in relation to their awakening sexuality. While increasing maturity can bring great pleasure and pride, it can also bring shame, sorrow and suffering. Reproductive health enables an individual to enjoy and control sexual and reproductive behaviour, with freedom from guilt, fear and other psychological, political and economic factors, and without suffering the control of another person.

In most cultures the male is expected to play a more aggressive role and the girl is expected to resist sexual advances and if she does not, blame, is more likely to be placed on her whatever may be the judgement of the legal system. At the same time, adolescents often lack sufficient knowledge and skills to delay sexual relations till they are ready. They risk not only social disapproval, they also risk unwanted pregnancy and sexually transmitted disease and tremendous psychological damage.

3. PREGNANCY AND CHILDBIRTH

Regardless of whether pregnancy takes place within, or outside of marriage, there are serious biomedical hazards especially for adolescent girls below 17 living in poor conditions and where access to health services is inadequate. The first birth of any woman carries greater risk than subsequent ones, especially for the adolescent. Her risk may be compounded by her lack of experience, knowledge and resources, and lack of social and familial support. Too early pregnancy increases the risk of maternal and child morbidity and mortality. At menarche girls have approximately 4% more to grow in height and 12-18% more in pelvic growth. They are at a greater risk of complications such as obstructed labour and of death.

The trend towards more unprotected sexual behaviour prior to marriage has given rise to increased risk of induced abortion, sexually transmitted diseases (STDs) including the new menace of AIDS. Problems of chronic morbidity, infertility and even death face the young person who is not protected.

However, access to information and services to prevent unwanted and too early pregnancy, and to protect oneself from STDs and AIDS, is often not available to adolescents. It is often misleadingly believed that sex education and provision of contraception with counselling will lead to promiscuity, whereas the evidence suggests the opposite.

4. ABORTION

Induced abortion (or pregnancy termination) offers a greater risk to the health and if an adolescent than to an adult woman. The reasons for this are several. An adolescent is more likely to hide pregnancy, unable or unwilling to seek appropriate health care, wait longer in the gestation period to seek help, and is more desperate not to have a baby. Self abortion or seeking abortion from an unqualified practitioner are more likely. Infanticide is another option that may be exercised. The psychological impact of such an act can be highly damaging.

5. STDs AND HIV INFECTION

and 2 Youth are especially vulnerable because of high risk behaviour greater biological susceptibility, limited access to STD treatment facilities, and the fact that primary prevention (always difficult) is the only effective form of control for HIV and other STDs.

Higher rates of STD are generally observed in the 20-24 year age group, followed by 15-19 and 25-29 year olds. However, in nearly all parts of the world, the peak age of infection is lower in girls then boys. In many countries, 60% of all new HIV infections are occurring among 15-24 year olds, with a female to male ratio of 2 to 1.

Young adolescent females are especially vulnerably because they tend to marry, or have sexual intercourse with older men who have had more sexual exposure. In addition, as a receptive partner, females run a greater biomedical risk to begin with. The risk is magnified in teenage girls because their immature cervix and limited vaginal secretions provide a less efficient barrier. Nor do they have the assertiveness or negotiating skills to induce their male partner to use a condom. To compound matters, young girls are sometimes physically forced to have first intercourse, leading to genital trauma with increased risk of infection. As if this were not enough, STDs in women are more likely to have mild or absent symptoms. Nor do the women find it easy to seek medical care for their STDs. Lastly, one should not lose sight of the role of prostitution, including child prostitution in the spread of STDs and AIDS.

6. TOBACCO, ALCOHOL AND OTHER DRUGS

Aggressive advertising targeting the young to promote tobacco use has shifted from developed to developing countries. The use of risky substances, including tobacco, alcohol and other drugs together than a significant effect on health in later life, rasing the risk of cancers, cardiovascular diseases, respiratory

diseases, cirrhosis of liver etc. Alcohol and drugs moreover impair judgement, and are likely to increase risk taking behaviour of young people such as the hazards of unprotected sexual relations, of accidental injury and of violence. Consumption of alcohol and tobacco by a pregnant mother can also harm the fetus.

Tobacco is the most widely distributed in the world tody, and arguably the most harmful smokers are also more likely to use alcohol and experiment with other drugs.

Disinctions that once separated cultures, sexes and social classes are vanishing as young people in developed and developing countries are increasingly using alcohol (although males generally use alcohol more than females). Indeed adolescents all over the world are getting increasingly influenced by the electronic media and are becoming fellow members of the "adolescent global village", where peer pressure and the roles models hold sway.

7. VIOLENCE

Violence against, and by, youth is finding frequent mention in the daily press. One of the most pervasive issues in today's world is violence against women. The adolescents are especially vulnerable. In 1993, the United Nations General Assembly adopted a declaration against physical, sexual and psychological voilence against women.

It is difficult to get reliable data on the problem, because of the "shame" of the victime, and the threat of further violence. Violence breeds many problems, and mental health consequences including post-traumatic stress disorder, depression, anxiety, sexial dysfunction, eating disorders, suicide and more violence, even including homicide.

8. MENTAL HEALTH

Adolescence is a period of change, and a period of stress. It is characterized by uncertainities about their own identity, their possible position in their peer group and in society at large, and their responsibility as adults. The need for parental approval has to battle with the need for independence. No woner adolescents show mood swings, and may even indulge in self-destructive behavious such as use of alcohol, drugs, suicide and violence. They need to be treated with

openness, understanding and sympathy, and offered creative channels for their energy.

9. ADOLESCENT LABOUR AND HEALTH HAZARDS

Most of the child labour is constituted by the younger adolescents. They are generally employed in cottage industries such as carpet making, bangle making, and as held in mechanical repair shops, eatries, and as domestic held. Adolescents labour deprives the young adolescent of opportunities for education and healthy psycho-physical development.

The actual magnitude of the problem of child labour, particularly urban working children (which includes street children), is not knwon due to the lack of accurate survey and a comprehensive definition of child labour. Thus, it is very difficult to estimate the actual number of child workers in urban areas and hence we are compelled to rely on rough estimates made by different groups.

According to official reports, there were 17.36 million working chilren in India in 1985, 95 per cent of whom were found in rural India. As per the estimates mady non-governmental organisations, the number of child laborers ranged between 44 and 100 million in 1985. whatever may be the truth, it is certain that the number of child laborers in India is very high. During the period 1961-81, child lahour was 5.66 per cent of the total child population and 6.22 per cent of the total labour force.

In 1981, the total number of working children was 13.59 million. Of this, nearly 10.69 million child laborers were found in nine states. Andhra Prudish had the highest number of child labour (1.95 million) followed by Madly Prudish (1.70 million), Maharashtra (1.56 million), Karnataka (1.3 million), Bihar (1.07 million), Tamil Nadu (0.98 million), Rajasthan (0.81 million), Orissa (0.71 million) and Gujarat (0.61 million). Of the totalchild labour of 13.59 million, the extent of urban child labour numbered 1.05 million in 1981. However, this data excludes children working illegally in unorganised units an those engaged in marginal activities.

Of the total of 1.05 million urban working children, nearly 0.805 million are concentrated in nine states among which Tamil Nadu has the highest number of urban child labour (0.151 million) followed by Andhra Pradesh (0.137 million), Uttar Pradesh (0.125 million), Karnataka (0.124 million), West Bengal (0.074 million), Madhya Pradesh (0.067 million), Bihar (0.044 million), Rajasthan (0.041 million), and Orissa (0.029 million). Moreover, in 1981, the sex-wise distribution

of urban child labour in India was 0.76 million and 0.29 million respectively for boys and girls. Relatively Tamil Nadu had the largest number of working boys (0.095 million) followed by Anhdra Pradesh (0.092 million), Karnataka (0.084 million), Maharashtra (0.075 million), West Bengal (0.047 million), Madhya Pradesh (0.045 million), Bihar (0.036 million), Rajasthan (0.031 million) and Jammu and Kashmir (0.012 million)

In the same year, Tamil Nadu had the highest number of girl child labour (0.056 million) followed by Adnhra Pradesh (0.045 million), Karnataka (0.039 million), Maharashtra (0.034 million),, West Bengal (0.027 million), Madhya Pradesh (0.022 million) and Rajasthan and Uttar Pradesh (0.01 million each). It is clear that in 1981 child labour was mostly concentrated in nine states, of which six states, namely, Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra, West Bengal and Madhya Pradesh had the maximum number of urban working children, both boys and girls.

In 1981, the highest percentage increase in total child labour was in Jammu and Kashmir (55.7 per cent) followed by Delhi (41.2 per cent), Meghalaya (30.0 per cent), Maharashtra (27.8 per cent), Madhya Pradesh (23.4 per cent), Tamil Nadu (22.2 per cent) and Karnataka (19.4 per cent). Compared to previous analysis, this indicates a different trend of increase in the incidence of child labour in differnt states, the growth rate of which was different in various states during the period 1971-81.

In States having lower urban literacy rates, we find higher incidence of urban child labour UP has the lowest urban literacy rate (52.6 per cent), the rates for some other states being Andhra Pradesh (58.9 per cent), Bihar (59.4 per cent), Madhya Pradesh (61.7 per cent), Orissa (62.3 per cent), Gujarat (68.3 per cent), West Bengal (68.7 per cent), Karnatak (69.3 per cent) and Tamil Nadu (70.9 per cent).

Urban working children in India are mainly concentrated in nine states and in some of the metropolises, such as Delhi, Calcutta, Bombay, Madras, Hyderabad, Bangalore,Kanpur etc. The incidence of urban working children is greater in states where the incidence of urban poverty and unemployment is also higher. Though the urban literacy rate and the incidence of urban child labour are somehow related, we cannot infer anything definitely about relationship between these phenomena.

As regards girl child labour, the sahre of male child labour in urban India is high, as is the Census in 1981.

This section of the working class is confronted with the highest level of brutalisation, physcial and psychological damage resulting it to fractures childhood systems. Long hours of work, inhuman treatement by the employees,

parental neglect, hazardous conditions of work have long-lasting negative influence on their psyche and maining and mutation of their bodies.

SUICIDE

Among HIV and AIDS patients 60% of people committed suicides or had made attempts once or twice earlier. It is therefore, imperative that such people be identified who are vulnerable to suicides and preventive action be planned. In the 21st century the youth may have to face tremendous emotional stress and strain at work, in the family as well as society. Suicide levels in schools was noticed due to failures in examinations or not getting high graes as per their parents unrealistic expectations. During anti-mandal agitation, 150 young people had committed sucides and suffered self-immolation. It was in this regard that efforts may be made to organise crash courses for stress management and identify potential suicidal youth. Pregaling suicidal behavious among youth is a consequence of academic stress, inability to cope with lif challenges, socio-cultural practices, religious bonds, community with high divorce rates, dowry, fear of stigmatisation, lack of communicability with parents and family breakdowns. Sone suggestions provided by him to address this problem include (I) mental health care system with strong prevention and aftercare networks, (ii) crash courses on youth stress management skills and techniques, (iii) identifying protential suicide prone condidates and develop action plans through team building for crisis management, (iv) special youth programmes for youth prone to emotional stress, (v) role of rural youth organisations, and (vi) public awareness drive on management of mental and physical trauma etc. (vii) Organisation of mutual counselling sessions where *anxieties/feelings can be shared.

The National Perspective Plan for Youth (NPPY) when considering long term planning has taken into account the existing and futuristic socio-economic and cultural trends. In such a case one had to take the views to futurologists, as it was observed that futuristic socio-economic and cultural trends. In such a case one had to take the views of futurologists, as it was observed that futurology is a growing science in the present context. In this context, youth health policy should provide opportunities to instill confidence among youth, the new set of idioms, rationale, images and orientation of health of their own as a part of the complex socio-system. The preventive approaches should be more focussed on behaviour rather than pathophysiology or curative aspects. Youth force should act as conveyor belt in youth health planning in terms of community participation, governmental efforts, inter-disciplinary approaches of medical, social scientists, etc. and there should be a shift of focus from microcosm to environment and from treatment to prevention. The doctors while managing youth behaviours must be familiarized with its, on the other hand extensive training to youth and organisations on health related activities etc would have to be provided. The youth should have a life span view in order to increase their

life expectancy. Long hours of TV watching and sedentary life should be discouraged by providing more opportunities for fitness campaigns and attitudes of having out-door activities. Recent development on Gene Therapy to manipulate features of children has also adverse effects. In this regard, guidelines would have to be developed for curtailing this fanay approach and prevent research on genetic issues. Lastly, with the advent of social and community medicines, a new medical discipline on Adolescent Medicine may have to be developed.

There is a need to evolve policies and programmes which would facilitate young people to know the ways and options of protecting themselves and to strengthen self-esteem and negotiating skills. Programme policy should have appropriate IEC intervention to dispel the wide range of existing misconceptions and fears among young people about the pandemic of HIV/AIDS.

10. DISABILITY

Disabilities among adolescents and youth comprise of mainly four types.

a) Visual
b) Hearing
c) Orthopedic
d) Mental

These can seriously interfere with normal development and functioning. They call for concerted efforts at rehabilitation, and bringing into the mainstream of life; which require efforts at all levels - Government, community, and the family.

If we take 4% as the reasonable estimate of disability following International Labour Organisation (ILO) guidelines, the number of disabled persons in India was 34 million in 1991. The number of disabled persons in the working age of 18 to 45 years was 8 million.

Cognizance should also be taken of the socially handicapped adolescents and youth, such as the patently deprived (orphans), beggars, street children and others exploited by criminals and drug dealers etc.

11. ACCIDENTS AND INJURIES

The magnitude of the problem of accidents and injuries is certainly increasing due to increase in traffic and industrialization. The changing level of risk behaviour by the young people also contributes to the problem (unsafe driving, use of alcohol and drugs, aggressive behaviour etc.

Suicides, violence, and homicides are the more serious aspects of the problem.

There is urgent need to collect more data on these problems.

12. SEXUALITY AND BEHAVIOUR

Consumerist culture, about sexuality have made the most intimate human relations i.e sexual activity, a highly commercialized and/or consumerist turn. Innocent youth make experimentation on human bodies the way they try any new consumer item-food, films, bidi-cigarette, alcohol & drug. induction of young girls and boys into sex trade has taken an institutionalized form among all sections of society - the poor, the middle class and the rich. Except for women's organisations no one has done any concrete work among the victims of misled sexuality

While the dimensions of time and space have shrunk, the dimensions of individuals have enlarged due to worsening economic crisis and social tension. The degeneration of the family system, society, and culture as a whole has occurred. This is the cry of the senior generation which is above the present youth and adolescents of today who certainly do not agree with this sentiment. Today we witness an egocentric society based on contractual basis and personal effort. The youth wish to create their own world in which they try to live by themselves and for themselves. In this situation, only development organisations equipped with proper knowledge can make headway in dealing with the problem of sexuality.

13. DEVELOPMENT ORIENTED MEDIA AND THE YOUTH :

Media in any form is a powerful instrument to alter the behaviour of people, especially of teenagers. May it be the print media, audio-visual electronic media, or performing art media, or may be even writing on the wall. In the modern world, media is not only effective, but also it is perniciously infective. The electronic media's speed is faster than the wind which travels across the seas. Enormity of adolescent health problem makes it imperative to create a cause of professionals competent to deal with variety of health issues faced by the youth in a manner which does not victimise the victim. With an interdisciplinary approach, we need to handle individuals and the existing system in such a way that humanizes the tarmentors and empowers the victims. Training programmes of Development oriented media need to draw on the

collective visdom of medical professionals, mental health experts, social scientists, scientists and technocrats. For effective social marketing of expert knowledge and new methodologies of dealing with the problems decision-makers of the government departments, criminal justice system, state administration and the voluntary organisations need to work in partnership.

GENERAL HEALTH; REPRODUCTIVE HEALTH AND SEXUAL HEALTH

- Nutritional Needs of the youth
- Balanced diet
- Energy expenditure of the working youth, school going youth, sports persons.
- Problems
- Anemia, Strunted growth, Malnourishment
- Mortality Pattern
- Morbidity Pattern Food-Security - Pds
- Anorexia nevvasa - psychological aspects
- Evolution of Government Programmes - ICDS - Role of Anganwadi workers, youth volunteers, teachers.
- Voluntary efforts - Youth Clubs, NGOs, Panchayat, Mahila Swasthya Sanghs, Mahila Mandals, NYKs.
- Training Programmes
- Performance of Implementing agencies - leakages and way outs.
  1. Health of Family Welfare Department
  2. Women and Child Development
  3. Deptt. of Education
  4. Deptt. of Rural Development
  5. Deptt. of Tribal Development
  6. The UN System
- Implementation of child-marriage on women's health
  a) Necket in nuntmance.
  b) Body not prepared for sexual activity.
  c) Stunted growth due to teenage-pregnancy.

REPRODUCTIVE HEALTH AND SEXUAL HEALTH

Knowledge about Reproductive Physiology

Reproductive physiology is an important aspect of sexuality and reproductive health. Parents are normally reluctant to discuss about such matters with their

children. They also object any such move from school or NGOs as they fear that such information may encourage promiscuity. Thus, in the prevailing cultural values in which talking with children about sex and related matters are still considered as taboo, the adolescent boys and girls have hardly any access to sources from which they could get reliable and authentic information on reproductive physiology and sexuality. Because of such constraints, many adolescents do not have information about sexual behaviour till their marriage which in turn sometimes affect their ,marital life quite adversely (Khan, et al, 1996)

Table 8 : Level of Knowledge among Students about Reproductive Physiology

(Percentage)

	Boys	Girls	All
Reported changes that occurs to a girl at puberty *			
Change in Size of breast	69.6	83.8	76.3
Starts menstruation	56.7	82.5	68.3
Hair in private parts of the body	65.2	82.9	73.5
Dont' know	21.5	10.8	15.1
Reported Changes that occurs to a boy at puberty *			
Change in Voice	76.7	74.2	75.5
Hair in private part of the body	84.8	65.0	75.5
Others	11.1	7.5	9.4
Don't Know	9.3	26.3	17.3
Total No. of Students	270	240	510

* Percentage adds to more than 100 due to multiple responses.

A study among 510 students of 8 schools in Lucknow shows that they were not fully aware of physiological changes that occur during puberty. However, girls were more aware of such aspects for boys only (Table 8). This shows that awareness of reproductive physiology that on these aspects, knowledge of the students of private schools is much better than their counterparts in public (government) schools.

An analysis of questions on attitude towards sexual practices shows that about one-third of the students do not object to premarital sex, particularly if both the partners agree for it. Boys, as expected appeared to have more liberal attitude towards sex and is reflected by the fact that only 47 per cent boys against 63 per cent girls considered pre-marital sex as sin. It is also interesting to note that, the

students of private schools appeared to be less liberal to premarital or extra marital sex than students of public schools.

The study points out that country to the general belief, sex and family education or awareness with family planning methods and sexuality will not promote promiscuity. The results of the study supports this. The students of the private schools although demonstrated a much better awareness of reproductive physiology, contraception and progressive attitude towards a healthy mixing with opposite sex, indulged less into sexual acts compared their counterparts in public schools. It is possible with detailed information about sex and positive orientation towards sexuality, they have learnt to say 'No' to premature sex.

Age at First Birth

Any pregnancy before completing 18 years is considered as high risk pregnancy. Both national and international data show that chances of developing pregnancy complications leading to serious maternal morbidity and even mortality is significantly higher among those who become pregnant and deliver child before completing 18 years than those who deliver their first child between 18 and 34 years.

Table 9 : **Age at First Birth by Age of Women and Residence** (Percentage)

	<15	15-17	18-19
Rural			
15-19	3.4	13.5	4.8
20-24	6.1	27.0	21.4
25-29	6.5	30.9	23.3
30-34	6.5	30.6	24.7
15-34	5.4	24.4	17.3
Urban			
15-19	1.6	5.9	2.9
20-24	2.6	13.5	17.5
25-29	4.0	18.3	19.2
30-34	3.6	19.9	20.7
15-34	2.8	13.7	14.3
Total			
15-19	2.9	11.4	4.3
20-24	5.1	23.2	20.3
25-29	5.8	27.3	22.2
30-34	5.7	27.4	23.5
15-34	4.7	21.4	16.5

Source : NFHS, 1992

NFHS data shows that one-fourth of the women aged 15-34 years had delivered their first child before completing their 18th birthday (Table 9). The corresponding percentage for the rural and urban area are around 30 per cent in 30-34 age cohort to around 14 per cent in 15-19 age cohort. Even with this declining trend, in absolute number the women in the age group 15-19 who start child bearing before completing 18 years is very large (2.6 million).

For instance, early entry of women in reproductive process results in prolonged reproductive span, and thereby, contribution to high fertility rate. Even if the adolescent mothers have fewer number of children, but at shorter interval, they contribute to high population momentum by narrowing the generation gap. Similarly, early child bearing also increases the risk of infant deaths which is known to be high among adolescent mothers. Finally, there are ample evidences that early child bearing and short birth interval contribute to high maternal morbidity and mortality as well. According to Registrar General; in 1987, 45 per cent of all maternal deaths in rural India took place among women aged under 24. In a hospital based study covering 55 medical college hospitals, ten district hospitals and 3 community blocks from 1992-94, 8.8 per cent of maternal deaths were among teenagers, while 80.6 per cent were for women aged 20-35 years (Bhatt, RV, 1996).

Contribution of Youth To Total Fertility

As can be seen from the Table 10, 17 per cent of the total fertility of the country is contributed by adolescents, i.e women between 15-19 years. Another 34 per cent is contributed by women in the age group 20-24. Thus, these two age-groups taken together contribute almost 50 per cent of the total fertility in India. The table further shows that 91 per cent of the total fertility in the country is contributed by the youth population falling in the age-group of 15 to 34 years.

Table 10 : **Age Specific Fertility Rate and Contribution to TFR**
(Percentage)

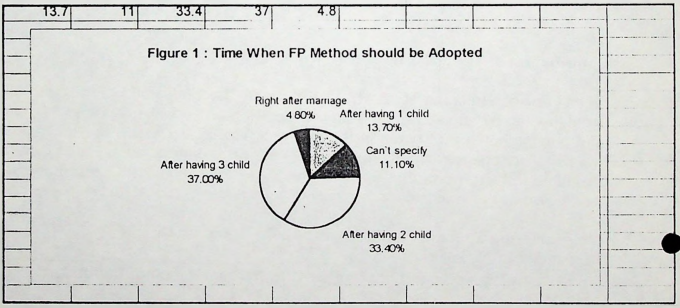
	Age specific fertility rate	Percentage contribution to TFR
Age		
15-19	0.116	17.1
20-24	0.231	34.1
25-29	0.170	25.1
30-34	0.097	14.3
15-34	0.614	90.6

Further analysis reveals that the women in India not only start child bearing at very early age but also produce children in quick succession, thus, completing

their desired family size at an early age. According to NFHS data, for fifty per cent of the women the interval between last two births was less than 31 months. Such short intervals are associated with high risk factors, which lead to various pregnancy complications.

Attitude Towards Family Planning

No significant attitudinal difference towards family planning is observed across the three age cohorts, i.e, 15-19, 20-24 and 25-34. Further analysis, as presented in Figure 1 shows that, a very small proportion adopts a contraception right after marriage or after first child. Majority adopt acceptance of family planning only after having second or third child. This conditional approval to family planning both by males and females has significant bearing on early acceptance of contraception for spacing purposes. Unless favourable attitude is developed towards the acceptance of family planning at early child bearing stage, acceptance of contraceptives for spacing purposes would not be easy.



Use of Contraceptives

One important determinant of fertility decline is use of contraception. The following table gives the age-wise distribution of current use of contraception among currently married young women in India.

Table 11. Percentage of Currently Married Women (15-34) by Contraceptive

Method Currently Used, India 1992-93

(Percentage)

	Any Method	Any Modern Method	Any Modern Temporary Method	Tubectomy	Vasectomy	Pill	IUD	Condom
Age				Urban				
15-19	9.8	7.7	6.6	1.1	0.1	1.7	1.7	3.2
20-24	26.7	23.0	13.2	9.5	0.3	2.2	4.6	6.4
25-29	51.2	44.9	17.4	26.5	1.0	3.1	6.2	8.1
30-34	64.2	57.3	15.2	40.0	2.2	2.2	5.3	7.5
				Rural				
15-19	6.6	3.4	2.0	1.3	-	0.6	0.4	0.9
20-24	19.3	15.6	4.3	10.8	0.4	1.4	1.4	1.5
25-29	39.1	35.1	5.1	28.8	1.3	1.4	1.9	1.7
30-34	52.4	48.3	3.8	41.3	3.1	0.9	1.4	1.5
				Total				
15-19	7.1	4.0	2.7	1.3	0.1	0.8	0.6	1.2
20-24	21.0	17.3	6.4	10.5	0.4	1.6	2.1	2.7
25-29	42.4	37.8	8.4	28.2	1.2	1.9	3.1	3.5
30-34	55.9	50.9	7.2	40.9	2.8	1.3	2.6	3.2

Source : PRC & IIPS, NFHS report, India, 1992-93

As our family planning programme is sterilization based the picture of heavy female sterilization seems to be more popular among the youths. Quite naturally use of this permanent method increases with age. The young women should be motivated to use spacing methods. They can be motivated to use permanent method after age 25 or 30 when they have achieved their desired family size. Use of contraception is much higher in urban areas compared to rural areas. But for the age group 30-34, the use of vasectomy is 2.2 per cent in urban areas compared to 3.1 per cent in rural areas. Use of tubectomy is higher among rural women. Use of condom is considerably higher among young urban women (Table 11).

Need For Sex Education And Counselling

The adolescent in India is in a dilemma. Western culture is clashing with eastern upbringing. Also increasing female education and industrial life has changed aspiration of the people. The sexual behaviour is changing in the cities in India nd the changing environment promotes the young boys and girls to experiment with unsafe sex. In the present world of STDs and HIV/AIDS these experiments may have and are having fatal outcome. It can lead to a generation of infected and debilitated people which will have serious socio-economic consequences.

It is therefore, imperative that attention be focussed towards, the apathy adolescents/youth which continues despite the recent interest created by AIDS prevention programme. The FPAISECRT survey of 1993 showed the while over 70 per cent knew about AIDS only 1/3rd of them knew about common STDs like

gonorrhea. This indicates that efforts for family life education has to be made more seriously and it has to be extended to both urban and rural sectors.

AIDS and Sexuality Transmitted Diseases

Youth planners for HIV/AIDS education must realise that the epidemic is controllable in a way that outbreaks of typhoid, hepititis, malaria or the flue are not. An individual can protect himself herself in way she/he cannot protect against other diseases. For example, infected food and water jaundice mostly beyond the control of consumers, cause typhoid and hos of other diseases, nearness to a patient can cause flu, a sting from a mosquito can cause malaria and even dengue. Fortunately, HIV doesn't spread by such vectors at all if young people could be educated to practise Safer sex, India's HIV epidemic would taper off. Therefore, it is possible to see an India totally free from HIV/AIDS by the year 2020. The high degree of popularity and success of the University Talk AIDS programme is an encouraging indicator of how youth could be mobilized for youth health and HIV prevention.

One area in which the youth themselves can play a vital role is prevention - counselling. Traditionally young people are more willing to listen to their peers on matters relating sex. Thus prevention counselling by youth for the youth can be designed to assist young people in making choices about their life style and practices. This may include support for all those who are interested in changing their behaviour to avoid HIV infection.

Past experience has shown that it is possible to mobilize thousands of young people under a purposeful scheme to work as Health Scouts. Such a scheme should include all components of a health promotion and disease prevention programme. Long and short term training needs of these Health-promotion volunteers need to be assessed.

HIV/AIDS prevention and education programme cannot succeed without active support and involvement of the formal Health Sector and NACO. Since youth are going to be the affected by the pandemic. It is essential to establish a high power Joint Committee of Health and Youth Sectors to provide policy direction and resource support to the field agencies. A special youth health division in the Health Ministry and another Youth Health Programme Division in central and State Youth Ministries may be considered to provide sustainability to the issue until it is brought under complete control.

Substance Abuse

A major health issue that has drawn maximum number of youth to its fold is substance abuse. Habit forming exposure to tabaccoo, alcohol and drugs start at a very early age with grave consequence for health in later life. A study conducted in late eighties on the average age of drug users in India indicates that 8.1 per cent of them were in the age-group of 11-26 years. And most of the world's drug users are between 18-35 years of age (UNDCP). The period of youth is a critical transitional phase marked by a continuous search for self-identity and self-discovery. Curiosity and quest for new experiences motivate them for experimentation. Young people in schools, colleges, factories, farms and clubs sit, eat and work together. New ideas and experiments keep circulating in these groupings. It has now emerged as major preventable cause of morbidity and mortality in most parts of the country. Broadly five categories of youth are considered vulnerable to drugs. They are :

I. Youth with personality and emotional problems.

II. Youth who are curious and involve in drug taking for kicks or experimentation.

III. Youth who take to drugs for escaping social, academic or domestic tensions.

IV. Youth who are under peer pressure to conform to a group norm ; and

V. Youth who take to drugs for enjoyment.

Studies have shown that the reason for the young people taking to drugs for the second or third time is not because the drug is highly enjoyable or they liked it very much. The youth take to it for a **variety of social and personal reasons** that have little to do with the effect or experience of drug as such. Connected with it are a **host of rituals, beliefs and symbolic meanings** that make drug use appear pleasant, special and glamorous.

These assumptions and practices need to be studied properly adopting principles of social marketing. Such studies should include **bahavioural pattern and trends of interest** among youth. Comparable results from surveys of various youth groups should form the basis for the development of a comprehensive preventive programme corresponding to the needs and interests of the young people.

Moral and spiritual education is considered by many as a preventive method. Setting up a network of information and activity centre to involve youth in creative programmes and **skill training of their choice** would definitely act as a barrier against the drug-addition. Combined with a **countrywide sports, youth exursion and recreational programme** to strengthen the intervention further. **Training youth in counselling** and preparing **NGOs to function as institutions for promoting family life education and responsible parenthood** would further contribute to the efforts. Youth on the **threshold of matrimony** need to be covered specially.

Families, being the **primary enviornment** for the children to imbibe values and norms can exercise effective control. If parents themselves smoke, drink and use drugs, the children won't need to go outside to learn these behaviours. Child neglect and wife beating is a typical problem in all drug abusing families. Children who run away from such families are only exposed to a more violent world. Deprived of concern and control they become victims of fear and violence.

The focus should more and more be on preenting young people from becoming drug addiots than trying to treat the addicts. This would require a **strong parent-teacher-community initiative to constantly and jointly monitor** vulnerable adolescents.

A major gray area is the lack of personnel trained in adolescent counselling. Special schemes may have to be launched to equip youth clubs with counselling skills and facilities. **Youth Awareness Courses** can be offered by NGOs having expertise in this field. Young people tend to respond more actively to approaches that involve and allow them in programme planning and implementation. Through such interventions young people would feel more confident to cope in a society where drugs proliferate.

Integrating drug abuse education into curricula with focus on healthy life-style can be one of the many alternatives to wean away the adolescents from the destructive path of drugs.

Adults have the potential and power to provide young people with **positive leadership and constructive role models.** Mass media, advertising agencies, opinion leaders are in a unique position to give accurate information about drug abuse to the general public in creative and credible ways. Highlighting drug abuse, although well intentioned, has done lot of damage to the issue. Films continue to project drug addicts as protagonists who eventually get reformed by the power of romantic love. Tele serials, radio plays and stories in print media discuss and dishout an overdose of information making young people conclude 'drug' as the real thing', an exciting adventure with potential and promise of unknown pleasure. So, efforts may be made to **promote youth and community action groups** who could influence individual attitudes and behavious through community norms. Collaboration and networking between NGOs and Government agencies need to be strengthened.

Health care and services also need to modify their approaches by moving away from disease and treatment model to education and prevention with user friendly services for the affected individuals.

Policy and administrative measures should include regulating drug prices through taxation and enforcement, restricting and policing locations of drug

sale, regulating advertising which stimulate drug-use, controlling supply of drugs and rehabilitating the drug-deaddicted. **Social networking of community based organisations and families** could be developed as a social monitoring mechanism against the drugs.

If the human societies hope to live in a drug free enviornment, if they expect young members of the community to return home without drugs and drinks, then we need to have thorough understanding of psycho-sexnet problems among the adolescent boys and girls as well as sex-related medical problems.

The survey results in these areas, have shown (I) increase in incidence of STDs in the urban areas (ii) 10% of the total cases of STD reported at the STD clinies are from the teenage groups (iii) 50% of the total cases contract the disease while they are in their teem. This data-base given us realistic understanding of dealing with this problem with the help of medical intervention, state machinery, councelling by serial workers and sex-education. Specially vulnerable groupes happen to be migrat youth, girl-prostitutes/sex workers/call-girls, regular rape victims (both boys and girls) of homosexnal and heterosexnel nature. Homeless youth in the urban areas sleeping on the parametres, public gardens, railway platforms and near urban slum are the most vulnerable sections in this regards as they don't speak about it because of sheer helplessness and team of retaliation. Moreover they don't get facility of clean/safe public toilets and bathing facilities. Thus along with HIV/AIDS/STDs they suffer reproductive tract/tract infections

CRIME DELIQUENCY DRUG ABUSE AND VIOLENCE RELATED HEALTH PROBLEMS

Men has been using drugs since ages. Now because of Scientific understanding on its devastating implications on family dite, economic development, social fabric and moral standards, both state and the civil society have become alert, moreover, drug and alchohal are not limited to cottege-industry or home based production. Modernisation compled with combination and industrilisation have created a situation wheree all addictive items are marketed extremely aggressively and violently in the world market among the most valuable sections of society, namely the youth global nature of drug traffking and alchohal and drug trade being billion dollar industries, targetting on propoganda and rehabilitation programme to the victims will not generate anything but frustration among dedicated workers and health professionals. Burn out rate among Social workers working with the criminals, deling and the victims of drug abuse has made it for the NGOs work in close coleboration with the State apparatus and Criminal justice system.

Increasing competition in employment, stress due to transitional society, inbarisation degenerating nature system have left the youth of today to face a myriad of problems which had a direct or indirect effect on their health The National Prespective Plan for the Youth up to 2020 aims to create a congenial atmosphere and allocation of human, financial and technical resources to enable the youth to face this challanges by providing them with a good, effective and strong support system and character training.

Agressive marketing of all addictive items, inablility of the economy to absorb the youth (both educated and glorification) in a productive and satisfying economic activitesin the civil society are inter-related factors resulting into increasing rates and intensity of crimes, deliquency, drug abuse and physical/sexual violence. /so far most of the welfare and rehabilitate programmes have addressed themselves to individual victims and their physical and pscychological sufferings. There is a need for paradigin shift in this regard because people and institutions working with the victims find that majority of them happen to be boys and girls who suffer from self-esteem and diffidence due to parental neglect, imensitivity of educational system, condidtion of shelterlessness and abuse of any creative outlet. Focus on individual boy/girl's leads to unnecessary moralisation and victim-baiting, We must take cognisence of the fact that youth workers traffiking durg/alchohal/sex-trade find it very difficult to get out of the clutches of their employer who are protected by the existing system. Experiences of Institutions like Sneha Sadan (Bombay), Asirwad (Banglore), National Campaign against child-labour (Madras)and Nehru Yuva Kendra Sangathan in the North-East, U.P , Haryana here revealed that homeless youth, child-labourers living either in the slums or streets and youth form romedic tribes are the major victims of drug abuse, deliquency and HIV/Aids. Hence the issues concerning housing policy, public health and sanitation, non-violent and non-addictive recreational facilities should be given top priority . Morever the improvement of general health and medical services and pleaded for the extension of the same to remote areas and extend adequate physical education, yoga, recreation and sports activities for youth to wean them away from the evils of drugs and alchohol. Adolescence was a period where they were prone to drugs and other kind of such behaviour and indulge in pre-martial sex leading to AIDS. International studies show that persons of 25 to 40 years of age suffer most from AIDS which is the most productive healthy sections of society. WHO report assessed that by 2000 A.D. 45 percent of drug abusers will be in the age group of 18 to 35 years. Abuse of drugs started at the age of 10 reaching its peak by 18 years. Majority of drug abusers in North-Eastern States were within the 93% of addicts with 15 to 35 years of age. It was here that youth as a major segement of the society had a pivotal role for curbing the problem. In this regard, initiative may be taken to promote youth for youth programmes. On the other hand, adequate counselling services may be provided at homes, schools, colleges, etc. On ill-effects of drug abuse and also

sex education. Various Departments of Government of India had chalked out a variety of programmes for coping with the meance including Department of Youth Affairs & sports through NSS and NYKS in colleboration with NACO, Ministry of Helath & Family Welfare and World Helath Organisation . Under the NSS programme the Department of Youth Affairs & Sports had developed a special programme known as UTA (University Talks on AIDS) which proved to be a major success as an AIDS preventive strategy.

There is a need to develop a comprehensive blueprint for youth health development which would reorient the existing programmes to serve the special needs of youth and developing interventions to enhance accessibility and provide benefits to reach the youth masses. This blue print would also serve the special needs of youth and develop special intervention with a range of options and a variety of strategies. The factors responsible for drug abuse and its consequeces had to be realistically dealt with trough a holistic approach. The problem of HIV/Aids was a new trend and was associated with drug abuse. It was on the increase specially in the North-East which needed urgent attention. Smoking was the major cause for drug abuse. He urged upon providing services to various categories of youth including student and non-student, child labour, adulthood, and the like, while developing intervention for youth. Programme of Department of Youth Affairs & Sports NSS has a major infrastructure providing services through 1 5 million volunteers and it was intended to expand it also at the school level. One major innovative and successful programme under NSS has been the University Talks on Aids(UTA), even before NACO could materialise. One major organisation under this Department, the Nehru Yuva Kendra, which covered every district of the country and had at least 2 lacs registered youth clubs. Another strong youth movement is Scouts and Guides besides the Youth Hostels Association of India having 60 hostels catering to 1 lac population all over the country. These efforts had increased outreach programmes for youth. Keeping out reach of this network in mind, we need to accept that Prespective Plan is not only for and bu the Government but requires canvassing at different levels/faculties.

Shri K K Baksi, Secretary, Ministry of Wselfare, Govt of India, while delivering his opening remarks (Annexure-V) reterated the purpose of the symposium as one of the series of symposiums with which his Ministry had collborated to organise in an effort to prepare a National Perspective Plan for Youth. He pointed out that 74 percent of the total population of youth was in rural areas. He emphasised upon any investment for youth development would go a long way in making them self reliant and contribute to the socio-economic development of the country. In this regard, and integrated andinterdisciplinary approach would have to be pursued both by governmental and non-governmental organisations. Scheme like NSS and NYK can be geared to ameliorating the conditions of Youth from exploitation to facilitate participation in developmental activities. Highlighting the existing mental and physical health of

adolescence and youth as a consequece of improper education, nutrition, lack of affection, physical atress and strains in modern day living. Adoption of immediate interventions strategies with sufficient impetus to attend to the problem of drug and alcohol abuse and HIV/Aids has to be at the top in the agends. At present the Ministry is playing an effective role in awareness creation and prevention education in this regard by actively involving the yoth groups. In this endeavour for positive results and act as effective agents of change. Adequate attention may have to be given to childhood and early adolescence while developing interventions for prevention of HIV/Aids. The Ministry of HRD has made efforts to address this problem by adopting a scheme for assistance to coluntry organisations for prohibition and drug abuse prevention through a community based approach. Presently 270 non-governmental organisations were being funded by the Ministry to run 230 Awareness, Assistance and Counselling Centers and 129 Deaddiction cum Rehabilitation Centers. The Perspective Plan will make and effort in the direction of effective networking and linkages among NGO's for youth development for forging inter-ministerial and intra-ministrial linkages.

7 to 8 million people suffered from STD acquired during 19 to 35 years of age. About 45 million get infection when young mostly due to their ignorence about the nature of the problem and treatment facilities. It was found that there is co-relation between STDs and heart diseases. He highlighted that a fifth of all global adult HIV infections were in South and South-East Asia with a third of them being young women. Infection was basically though injecting and non-medical drug use. While 40 to 50 percent of prevalence was noticved among males, 75 percent of India's HIV carries were below 40 years. India's HIV infection was doubling every two years, and if the trend continues, it was estimated that it would be 4 million by 1996 and 16 million by 2000 would be HIV infected persons. Presently, 360 million men and women in 14 to 45 age group were sexually active and one million were yound commercial sex workers. Alarmingly, by 2005 A.D onwards the helath sector may have to invest Rs. 35,500 crores for HIV/AIDS only taking the present increading into consideration. By the first decade of 21st century, 10,000 Indians would die out of which 8,000 would be young people and 60 percent of hospital beds would be having patient of HIV/AIDS, if the existing trend is not arrested. 70 percent of AIDS patients lead to T.B.

SOCIAL AND MEDICAL SUPPORT MECHANISM FOR ADOLESCENTS AND YOUTH IN CURRENT SENARIO

THE EPIDEMIOLOGICAL TRAID

In the balance of positive health, there is a delicate balance between the three ever interacting entities that consitute the epidemiological traid, that is between the host, agent and the environment. These three exists in a state od dynamic equilibrium and determine the state of helath and disease.

The concept presumes that the host, the disease causing agent and the environment that produce good helath (positive health)or disease are always there. In case the host resistence to disease is good, the environment right and conducive, and/or the disease causing agent weak then a state of good health of the hosts exists. On the other hand, if the host resistance is weak and/or the *disease* causing agent strong or present in greater number (e.g bacteria) or more intense (e.g the qyantity of carbon monoxide in the air), or the environment conducive to facilitate the disease agent in causing the disease, then good health would cease and disease occur.

In thinking of any state of health, or disease the epidemiological traid explains genetic disorders this applies, as here factors inside the jose also work as the agent). *In the case of drug abuse, the user is the host, the drug is the agent and various social factors including the drug's availability the environment. All of them co-exist at any given time, yet the disease called drug/alcohol addition oocurs only when this balance is distributed by either the host becoming weak abd prone due to physical, psychological or social reasons, or the drug being more easily available abd in larger quantity or the social influences being, so conductive.*

Community worekrs working with the victims of HIV/AIDS and drug abuse have to shoulder major burden of providing emotional, medical and material support. Social stigma about these problems make parents and other family members shy away from them. This creates tremendous burn-out among Social workers who are left in lunch when they creak. This makes it mendentry for all concerned citizens to accept Social respensibilities and deal with this problem at a macro level. Social workers have to invest all their energies In individual victims. Criminal justice system can make effect intervention by esteblishing support with drug-lords and cultivators of drug-related plants, instead of slely concentrating on raids and brutashising the drug-peddlers. This can be achieved only when Social workers, development oriented media, police abd military force are able to establish support with pwoerful forces operating globally. Drug-peddler longuiting in prison are totally disowned by their own family memebrs. Only social workers have been able to touch hearts of this helpless victims. If they are used as power in the powergome, they can be effective change agents.

For overall health needs of the Youth of poverty groups state needs to provide need-based food-suply and helath-case facilities. Public health issues can be taught to the educated youth so that they can provide first-aid services,

para-medical services, media-legal advise and monitoring of medical malpractice. Voluntary Health Association of India, Media Friends Circle, Kerala Shastra Sahitya parishad, Forum for Medical Ethies, Health and Human Rights module envolved by CEHAT - Pene and Bombay, PPST Madras, preventive and Social health department of Tata Institute of Social Sciences here served great purpose in generating a cadre of well informed youth on health issues.

RECOMMENDATIONS :

Taking into account the populati0on momentum and its consequences on pollution growth and asociated socio-economic and health problems, the following recommendation s have been worked out after the two days of deliberations by participants in the workshop.

There is a need to change the present definition of youth from the present 10-35 years. The new definition suggested is the total population in the age group of 10-29 years as falling in the category of youth.

Providing employment and income generating activities for the youth is needed. With the organized sector becoming less labour absorptive, unemployment leading to poverty, mainutrition, ill health and unrest is inevitable. To prevent

such a situation it is imperative to provide alternative sources of satisfactory income generation to the youths.

Registration of vital events like birth, marriage and death should be made compulsory. Needless to say, this has many immediate and long term benefits.

No child marriage should take place before the legal age (18 years for girls and 21 years for boys) after the year 2005. It is to be noted that with enforcement of the legal age of marriage the unmet need for sex among the youth will increase and it is necessary to work out means to take care of this unmet need by providing alternative activitiesi and occupations to this segment of the population.

Establishment of peri-marital (before marriage, just married, after marriage) counselling services at convenient locations. These centres should not confine their activities solely to family planning, sex and marriage counselling and sex therapy but also include family welfare, child guidance, general health, nutritional advice and counselling for all the concerns of adolescent and youth, particularly STD and HIV/AIDS.

Ensure that 'zero' births take place after the third order birth from the year 2005 onwards.

All deliveries should be assisted by trained persons from 2005.

All abortions to be safely done in recognized institutions.

Family planning managers should involve the teen aged population also in their programme.

Since three-fourth of the Indian population dwell in villages, it is essential to integrate the rural and the urban youth, as also familiarize the urban youth with the rural sector. For this, urural posting of all graduates in various capacities should be made compulsory as the current practice exists only for medical graduates.

Need to devise Indian alternatives while planning programmes for the youth while taking into account traditional norms and values.

Planners and policy markers have to recogniiiize the needs of the adolescent, understand them and commit themselves to meeting these needs. A wide group of people including parents, teachers, social workers, politicians and policemen need training and orientation to help the youth achieve optimum health.

It is imperative to form an apex body at the central and local levels to co-ordinate the orchestrate of activities of the various departments like Health,

Education, Human Resource Development, Family planning and so on. The government has also to ensure strict enforcement of the laws . In this context the panchayat can play a key role.

Better and wider communication by involving the school community to introduce the concept of gender equality. Change stereo types and provide role models to the youngsters right from the school stage.

Provide family life education in schools and colleges.

Develop educative regional and local programmes to spread messages which are revelent and culturally sensitive for the community as a whole.

Impart training on gender sensitization to various sections of the society, particularly government officials, workers at the grassroot level and the community at large.

Make effective use of all possible media, particularly the folk media, press and radio for creating a conducive environment for social change. The existing network of scounts, NSS and Yuvak Mandal volunteers can be utilized to canvas and reach mesages to the youths at large at a personal level. This would be more economical, personal and effective with greater chances of percolating into their minds. as a sizable segment of population cannot be reached through conventional mass media, the only alternative is through word of mouth communication.

Devise strategies to effectively use the available infrastructure and netwok of agencies at local levels like the Panchayat, Yuva Kendras and Mahila Mandals rather than forming new committees and working groups. Involve NGOs and Panchayat to promote sensitization in the community.

Create a data base by gender on income generation and all other aspects such as utilization of health services, loan facilities, panchayat members and so on.

Make provisions for availability of information of women regarding legal, economic and health matters. This again should be done involving Panchayats,, Nehru Yuva Kendras and local NGOs so that the information is available in local language and is culturally sensitive.

Provide leadership training to women. Ensure more involvement of women Panchayat members in various programmes.

Sensitize and involve the males as partners. NGOs must step in and play an active role in devising programmes to involve males in reducing domestic and sexual violence. Also set up male clinics for their health services and counselling.

Effectively use the services of the senior citizens in youth programmes. This could be done by involving the older population expecially the retired ones to

take up the posts of technical support in youth organizations or be in-charge of logistics and infrastructure. This could serve the dual role of providing social/job security to the older generation while taking care of the younger one.

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TIME
SPEED DEMONS
An inside look at Asia's methamphetamine culture

TIME MARCH 5, 2001 / VOL. 157 NO. 9

JONATHAN TAYLOR FOR TIME

Speed Limits

Jacky and Nong would give almost anything to avoid a moment like this one. Coming down from a meth-induced high to the shabby reality of their Bangkok slum, their hunger for speed exemplifies the desperation that has made the drug's use a continent-wide crisis **Page 36**

COVER: *Photograph for* TIME *by Jonathan Taylor*

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WHILE WE TEND TO BE PROUD of all of the articles we produce each week, I urge readers to take a particularly close look at a pair of exceptional pieces in this week's magazine. The first, by deputy editor Karl Taro Greenfeld, is a stunning inside look at Asia's obsession with methamphetamines, or speed. Use of the drug first soared as working-class Asians struggled to keep pace with the region's breakneck economic development; it subsequently skyrocketed when boom turned to bust, and layoffs transformed many urban Asians overnight into have-nots who were desperate to escape their squalid lives. To report this story, Greenfeld spent five days and nights with a tribe of speed freaks in a Bangkok slum known as Do It Yourself Happy Homes. (The Thais call the drug *yaba*, or mad medicine.) His dramatic piece, twinned with the powerful black-and-white photographs of Jonathan Taylor, is magazine writing at its best: dramatically reported, wonderfully told. Moreover, Greenfeld brings to the story unique insight: as a young man in Tokyo years ago, he, too, struggled with chronic speed use. Says Greenfeld: "Reporting this story was one of the greatest personal challenges I've faced as a journalist. It was like visiting my own demons."

HITTING HOME: Greenfeld, left, and Ghosh show passion for their craft

This week's other noteworthy article is senior editor Aparisim "Bobby" Ghosh's account of Gujaratis' efforts to pick up the pieces after the devastating earthquake that struck Jan. 26. Soon after the temblor, Ghosh asked for a two-week unpaid leave to volunteer in the massive relief effort. Although he didn't go as a reporter, the tales he brought back were so riveting that we asked him to put them down on paper. The result is a gripping account of the walking wounded struggling to cope with the tragic 45 seconds that shattered their lives. There already have been many tales of the quake's merciless destruction, of miraculous rescues and of the initial efforts to rebuild the province. This is a different kind of story, an attempt to capture the fate of the survivors, whose damaged souls may never fully heal. For Ghosh, the effort was troubling: "Writing about my experiences meant having to relive them before my memory had a chance to soften their edges. I kept seeing the faces of all those traumatized people, hearing their voices."

These articles represent the pinnacle of journalism, where detailed reporting and elegant storytelling combine to offer memorable insights on important issues. Thanks to writers like Greenfeld and Ghosh, this is what TIME does best.

Adi Ignatius, Editor, TIME Asia

Buried Treasures

A Philippine con job involving absurdly fake U.S. bonds tapped into a local mania for bounty hunting

By TIM McGIRK CAGAYAN DE ORO

IN THE MOUNTAINOUS JUNGLES OF MINdanao, primitive tribesmen stumble upon the wreckage of an American B-17 bomber from World War II. In the twisted fuselage they discover several strongboxes with U.S. government markings. The stacks of printed sheets inside are worthless to the hunter-gatherer tribesmen but not to the city slicker who happens to pass by a few days later—he acquires them in exchange for a few trinkets. At this point in the tale, the narrator reaches for a rusty, banged-up box and pulls out a sheaf of the papers, seemingly yellowed by age: Treasury bonds, worth trillions of dollars. Now the narrator makes his dramatic offer: for a small downpayment, a big piece of this windfall can be yours!

Who would buy a yarn like that? According to the Philippine police, thousands of gullible Filipinos and others did, coughing up millions of real greenbacks to a group of Mindanao fraudsters now dubbed the Trillion Dollar Gang. The numbers could be higher: police say many victims are probably too embarrassed to come forward. They should be red-faced, having fallen for the crudest of cons. Using computers and rudimentary desktop printers, the gang ran off fake U.S. Federal Reserve notes in denominations from $100 million to $500 million. The total: $2.15 trillion, more than the annual American budget. The scam was blown by a joint U.S. Secret Service and Philippine police operation on Feb. 18, when they arrested one Mindanao ex-security guard; they are hunting at least six other suspects, including several foreign nationals.

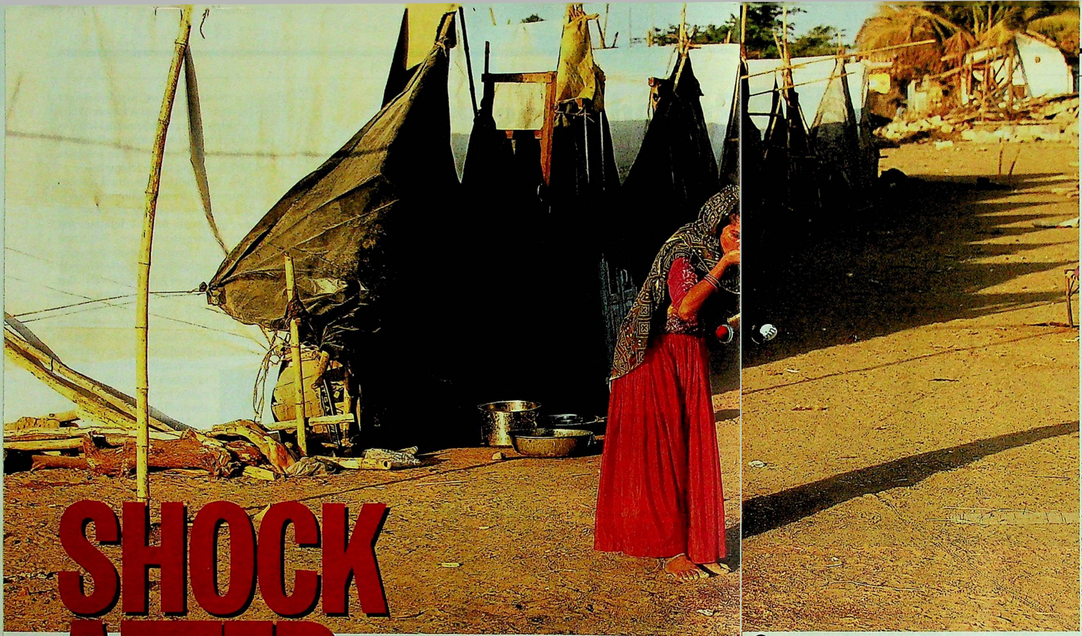
Going by the number of zeros on their notes, the Trillion Dollar Gang were certainly the most ambitious counterfeiters in history. Their victims didn't know that the U.S. government has never printed a bond larger in value than $10 million; nor did it matter that the fake dollar bills copied onto the bonds were sloppy blurs in which Benjamin Franklin looks like a blob from Mars. They were taken in by the tantalizingly credible story. All the fake bonds were dated 1934 and marked to "mature" 30 years later. Each of the hustlers told his victims the bonds were being demonetarized by the U.S. government, pulled from circulation in a matter of weeks, and that he needed some cash to pay his expenses to Washington, where he would redeem the Federal Reserve note before it expired. In exchange, he offered to pay back 1¼—or $1 million to $5 million—on every note cashed in. "It is the scam *du jour*," says U.S. Secret Service agent David Popp, a former White House bodyguard now stationed in Manila to protect U.S. monetary instruments against an onslaught of hustles, swindles and fakes that have sprung up in the Philippines.

REAL THING: U.S. Secret Service agent David Popp, above right, contrasts a genuine dollar bill against the fakes. Archie Mingoc, inset, is the only person who has been arrested

The counterfeiters' tale struck a chord with many treasure-mad Filipinos. Newspaper classifieds routinely advertise the services of psychic fortune hunters, and the four governments since Ferdinand Marcos' regime have embarked on searches for Japanese war loot—reportedly worth billions of dollars in gold and jewels—that was allegedly buried somewhere in the archipelago when General Yamashita Tomoyuki's forces retreated before the Allied invasion in 1945. The "primitive" tribes of Mindanao are often the first to capitalize on this gullibility. Says General Ruben Cabignati, regional military commander based in the town of Cagayan de Oro in Mindanao: "I know of so many smart businessmen who have been tricked by these seemingly innocent natives." It helps that Mindanao's prolonged Muslim separatist insurgency has created a lawless haven for kidnappers, arms sellers, drug traffickers and itinerant counterfeiters.

The first clues to the Trillion Dollar Gang were detected not in Mindanao but in Los Angeles. In early 1998, customs officials found fake Treasury notes hidden in the suitcase of a Filipino Jesuit priest. Investigators eventually traced the fake bonds to a shantytown on the edges of Cagayan de Oro. There, in the home of a security guard named Archie Mingoc, police found a box containing $1.38 trillion in fake bonds and stacks of counterfeit Japanese, Malaysian and Argentinian currency. A raid on the home of his brother-in-law, Renato Waban, yielded an additional $773 billion in bonds. Mingoc swears Waban, who has since disappeared, asked him to stash the box. Police believe Waban, who flew from Cagayan de Oro to Manila twice a week, may have acted as go-between for the Mindanao forgers and the ringleaders, some of whom may be Japanese, Americans and Europeans.

Popp for one isn't too upset that only one arrest has been made. It is enough, he says, that the publicity surrounding the bust has alerted Asian countries to look out for the fake U.S. notes. They're the ones with all the zeros. —*With reporting by Nelly Sim/Cagayan de Oro*



PRASHANT PANJIAR—LIVEWIRE IMAGES FOR TIME

HOME AWAY FROM HOME: Most earthquake survivors in Kutch now live in camps like this one, in Ratnal village. With entire cities flattened, reconstruction will likely take months, maybe years

SHOCK AFTER SHOCK

In quake-shattered Gujarat, many survivors will never fully recover from the trauma of those horrible 45 seconds. A first-person account

By APARISIM GHOSH KUTCH, GUJARAT

DRIVING INTO KUTCH, I'M UNNERVED BY THE DEVASTAtion on both sides of the highway: the TV images and newspaper pictures didn't prepare me for this mutilated landscape. The epicenter of the earthquake lies in Gujarat's western-most region, where the cotton fields of Saurashtra give way to the dusty plains of the *rann*, an 18,000-sq-km expanse that once was a marshland on the shores of the Arabian Sea but is now practically desert. The sparse vegetation is more brown than green. This inhospitable terrain is home to the Kutchi people, former nomads renowned for their hardiness. They, along with Gujaratis from the interior, have fashioned a sturdy local economy from the only two gifts nature has bestowed on this land: salt and sea ports. Over centuries, that economy built cities like Bhuj, Bachchau, Anjar and Rapar. It took the quake just 45 seconds to flatten them.

Having grown up on India's stormy southeastern coast, I have experienced some of Nature's terrifying moods. But not even a full-blown tropical cyclone can reduce a city of brick, stone and mortar into a mountain of rubble. An earthquake is especially terrifying because it shakes our most fundamental belief, that the ground beneath us is solid. Although I have volunteered to help in the relief effort, I'm truly, deeply, frightened—and will remain so for the duration as aftershocks, at least six a day, rumble underfoot. These are mostly mild, 3.5 to 4.5 on the Richter scale, and last only five or six seconds, but they are a constant reminder of the Big One.

Not that anybody in Kutch is likely to forget. Everyone I meet has a horrible tale. The vice-principal of a school in Gandhidham town saw a brick wall fall on her students. She wonders if she can ever return to teaching. A construction worker in Bhuj spent half a day shouting out encouragement to a woman trapped in the debris as others tried, in vain, to reach her; her last words to him were: "Be good to your family." Another man dragged two of his children out of their home and had just returned for the third when the roof came down; he and the child inside miraculously survived, but the two outdoors were crushed by a collapsing wall.

After a week working for a nongovernmental organization (NGO) in rural Saurashtra, I enlist as odd-job man in a kitchen tent on the outskirts of Bhuj. Not an instinctive volunteer-type, I have no idea why I'm here, just that those images on TV and in the papers demanded more than the routine cash-and-clothes donation. But there's not much time for introspection at the kitchen, run by Girishbhai, a small businessman. We serve two meals daily to quake survivors from nearby camps, anywhere between 150 and 450 people a day. After a couple of days, I realize I'm avoiding conversation or eye contact with the people we're feeding: I don't want to hear any more stories. But some horrors are impossible to escape. The stench of decaying bodies still hangs over parts of Bhuj two weeks after the quake. Elsewhere, there is the smell of burning flesh from funeral pyres. I'm grateful to have been spared the sight of smashed heads and twisted limbs.

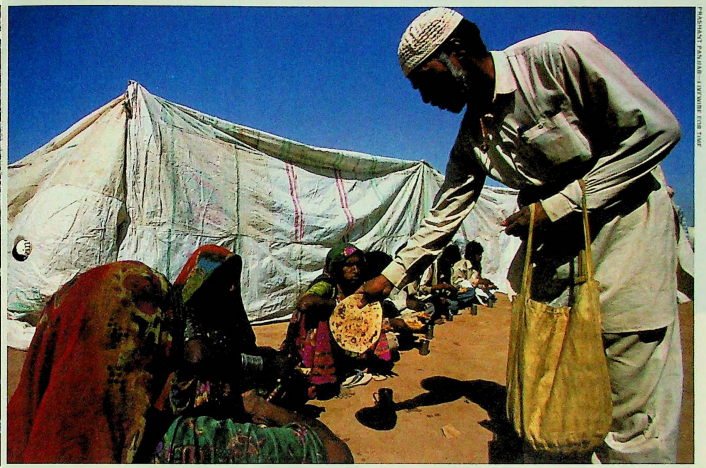
And then there are the walking wounded: the thousands of survivors whose minds cannot yet comprehend the full extent of their tragedy. Dozens of people who come to our kitchen bear the telltale signs of a nervous breakdown in progress, the stuttering, the facial tics. Many others are in deep denial, like Varsha, a Bhuj housewife in her late thirties. The apartment block that housed her third-floor flat has collapsed. Although she and her family were unhurt, the sight of all their worldly possessions going to dust has left her unbalanced. Every day, from dawn till dusk, she stands guard over the pile of bricks and mortar, "to make sure thieves don't take our things." There is no way any of her "things" could have survived; the building is so thoroughly destroyed I doubt a spoon is intact. But Varsha won't—or can't—give up hope. "We had a TV, a fridge... How will I know what's under there until they've removed the rubble?" she asks. She wishes the clearing crews would come quickly, with their cranes and bulldozers. But they are concentrating on wreckage where there's a chance of finding bodies. It will be several days, perhaps weeks, before they get to Varsha's home. "If only somebody in this building had died here," she laments. "Then the bulldozers would come and we'd get our things back."

NGO veterans who have worked at other disaster sites say most survivors will never fully recover from the trauma. Psychiatric help is hard to come by, and anyway, most people don't recognize the need for counseling. To some, seeing a "crazy doctor" is tantamount to admitting they are insane. The quake hasn't shaken people out of their ignorance, or false pride.

On the bright side, practically every other kind of aid has been pouring into Gujarat—food, water, blankets, tents, volunteers. More than any previous natural calamity, the earthquake has sent Indians everywhere into a frenzy of giving. The trucks streaming past Girishbhai's kitchen bear the license plates of 20 different states. (I counted.) Every religious group you can name has a camp and kitchen in and around Bhuj. Even Tibetan refugees have pitched in. Some folks have gone overboard in their generosity. There is a surplus of used garments, sent by the truckload from all over India. Just outside Bhuj, I see an enormous pile of clothes, evidently offloaded from a passing truck. Back in Saurashtra, one NGO is still wondering what to do with a truckload of shaving kits sent by some well-meaning souls from Bombay.

Some surpluses are welcome: Kutch has received more water in the past three weeks than in the previous two years. (There has been a drought since 1998.) In Anjar, I spot a group of urchins drinking bottled mineral water. Even the barren earth has turned bountiful: geologists report that the quake has created a new "river," a 100-km channel of fresh water from a subterranean lake is snaking its way across the *rann*. Hindu priests immediately pronounce this to be the Saraswati, the mythical holy river that disappeared into the ground thousands of years ago. Here and there, there are reports of new ponds bursting to the surface, but just as quickly disappearing.

In the tent cities that have sprouted around Bhuj, Bachchau



PRASHANT PANJIAR—TIME FOR KIDS

PRIDE GOES WITH A FALL: In villages like Chaubari, self-sufficient rural folk, left, are loath to take charity. But the quake has forced many to rely on the kindness of voluntary organizations, above

and Anjar, news of fabulous rivers and ponds is greeted with healthy skepticism. For the moment, though, most survivors are too busy grieving for their dead to be distracted by faux miracles. Many families remain in a state of suspended mourning, uncertain about the fate of missing relatives.

Sumati and Karsanbhai, encamped near Girishbhai's kitchen, are still waiting to hear from their 20-year-old son Vinod. He had left their home in Bhuj a few minutes before the quake struck, but there has been no sign of him since. Is he in another camp? Did he flee to his sister's home in Surat, to the south? Is his body lying lifeless under some mound of bricks and stone—or was it dumped, unrecognized, on a funeral pyre, like thousands of others? The couple, small and frail in their mid-fifties, are trapped somewhere between hope and despair. Every morning, Karsanbhai heads out in search of Vinod, circulating among the NGO camps, government emergency centers and military information booths. He calls Surat to check if Vinod has arrived there. Sumati, meanwhile, busies herself in the tent she now calls home, emerging sometimes to help other women cook and clean. She doesn't speak to anybody, but is constantly muttering to herself. Only when I draw within a meter of her do I realize that she is chanting the name of a family deity: *"Ma Sherawali... Ma Sherawali... Ma Sherawali..."* She clings to a small idol of the Tiger-Borne Goddess she found in the rubble near the camp.

Karsanbhai returns in the evening, grimy from sweat and worn from walking all day without food or water. He can't bear to look Sumati in the eye. "Any news?" she asks, keeping her voice as matter-of-fact as a mother's anxiety will allow. She knows the answer before Karsanbhai can deliver it: "No. Maybe tomorrow." At night, Sumati breaks down and wails for her missing son. Karsanbhai admonishes her: "Why are you grieving for somebody who isn't dead? You know we will find him, it's only a matter of days." An hour later, it's his turn to cry, and hers to scold: "I'm a mother, and my heart tells me he's alive. How foolish you will look when he comes here tomorrow, and finds you mourning." At dawn, Karsanbhai heads out again, and Sumati calls to *Sherawali.*

The camps provide more than food and shelter. Huddled together in the winter cold, survivors are forming informal support groups to cope with their collective sorrow. One morning, as Karsanbhai prepares to leave for his daily search, two men step up and offer to join him. If they go in different directions, three can search more effectively than one. A fourth man brings them some bottles of water. Overwhelmed by this gesture, Karsanbhai hugs one of the men, sobbing uncontrollably.

Not all survivors are in the camps. Many have left Kutch, even Gujarat, to live with relatives elsewhere. Some will never return. Others are reluctant to leave the ruins of their homes. A young woman, barely out of her teens, squats by the side of the highway not far from the sea bridge that connects Kutch to Saurashtra. She has a naked baby in one arm; the other is outstretched, seeking alms. But she obviously has no experience in begging, because she's a good 10 m from the road, too far to be noticed by drivers whizzing past at 100 km/h. Passing that way a week later, I see her again, still sitting a long way from the tarmac. This time I stop. She only speaks Kutchi, the local dialect, and understands very little of my Hindi, so our conversation is hit-and-miss. We get off to a bad start. I ask her name. "Balia," she replies. Her son's name? "Balia." And her husband's? "Balia." He is apparently somewhere in the *rann* foraging for food while she seeks charity by the highway. The pickings are slim. In 15 days, she has scored two olive-green blankets and a small bag of rice and lentils from a passing aid convoy. Her husband has come up with some onions. I offer to drive the family to a relief camp near town, where they would get food and shelter. Balia refuses, pointing to a small pile of stones that used to be her home. What if the government surveyor came around while they were in the camp? They would miss the chance to claim financial aid. I give her what I have on me, but a handful of biscuits and a few rupees won't last a day. So I urge her to move closer to the road, to improve her chances of receiving alms. She agrees, and accepts a gauze mask for protection from the exhaust fumes. I've done a few unpleasant things over the years, but nothing made me feel as low as having to teach Balia to beg.

BY THE TIME I LEAVE GUJARAT, THE CHAOTIC RELIEF EFFORT HAS been replaced by some semblance of order. After some prodding by New Delhi, the state administration has snapped out of its stupor, launching a welter of rehabilitation and reconstruction schemes and working with the NGOs. Many volunteer groups are pulling back, leaving the work to be done by organizations that have the best resources on the ground. This allows for easier coordination, ensuring that aid is spread evenly. Corporate India has responded magnificently to calls from the government, with many companies adopting entire villages. Thousands of wealthy Gujaratis abroad—think of all those "Motel Patels" in the U.S.—are sending money to impoverished relations or social service groups.

By tapping into its traditions of private enterprise and self-reliance, Gujarat will bounce back on its feet faster than many people expect. There will be a New Bhuj, a New Bachchau, a New Anjar. Today's rubble will be turned into tomorrow's construction material. Many of those who have been bereaved by the quake will also be enriched by the massive reconstruction effort. My own guess is that in 10 years the quake will have faded from public memory.

Private memories are a different story. I get a final glimpse into Gujarat's wounded psyche on my last night at Girishbhai's camp. Most of the people—mainly slum dwellers—seem in good spirits. Women gossip and giggle as they help the volunteers cook up a fresh batch of *khichdi*, a nutritious mixture of rice and lentils. The men are kept in splits by a barber's risqué jokes. "Our homes were not worth much, so it will be easy to rebuild them," says 60-year-old Haji Aftab. "We feel sorry for the rich and the middle-class folks, who lost expensive houses." The resident chatterbox Malati, a maid in her early twenties, says she is looking forward to the months ahead. "There will be so much construction work here, my husband and brothers will all have jobs," she says, grinning broadly. "When God takes with one hand, he gives with the other." But as night falls, Malati grows quiet, edgy. After dinner, she is the last person to turn in. Then, just short of midnight, we are awakened by a piercing scream from the women's tent. It is Malati, shouting in her sleep. "Get me out! Get me out!" I learn that she has been doing this every night since the quake. In all years there will be no physical evidence of the great earthquake of 2001. But in the nightmares of Malati and a million others, the earth will never stop shaking. ■

UNITED STATES

PARDON ME

Hillary says she knows nothing about her brother's dealings with her husband, but a new investigation may change that

By MICHAEL DUFFY and KAREN TUMULTY

BILL AND HILLARY CLINTON HAVE ALWAYS MAINTAINED a hygienic distance between their scandals, like His and Hers towels. He had Monica; she had cattle futures. He rented out the Lincoln Bedroom; she emptied out the Travel Office. Whitewater had separate plot lines: his lost memory, her lost billing records. And for a month, it looked as if the 177 clemencies Clinton granted in his final days were falling neatly into the His column. But last week it became clear that U.S. Attorney Mary Jo White was investigating some that have signs of being community property—the commuted sentences of four members of a Hasidic sect following a meeting, which Hillary attended, between sect leaders and her husband.

There is not much you can do to an ex-President. The realists know it's too late to impeach him and too hard to indict him, since bribery is a difficult charge to prove. But with the news of a broader investigation, the focus of the scandal expands to include not just the Clinton who is worried about his legacy but also the one who is worried about her future. So many of the people who were pardoned had connections to New York that it was only a matter of time before the spotlight expanded from the former President to the sitting Senator.

Not that it wasn't breathtaking to watch a shiny new ex-presidency disappear under a freak mud slide. The debris hurtled by so fast that the New York *Times* editorial page seemed to run out of synonyms for disgust, revulsion and abuse. Jimmy Carter, the perfect ex-President, broke the cardinal rule of the brotherhood and called Clinton's pardon of Marc Rich "disgraceful." Even Terry McAuliffe, the former President's friend, said that decision had been wrong. Perhaps worst of all, there seemed to be no end to the bodies that might float down the swollen river. Congressional investigators subpoenaed another Clinton fund raiser, Beth Dozoretz, to tell all she knows about his pardon of Rich, the billionaire fugitive living in Switzerland.

And shattering any doubt that Clinton's pardons were shaped like boomerangs was the news, broken by the newspaper of record in the Clinton era, the *National Enquirer*, that

VIEWPOINT

Charles Krauthammer

The Bush Doctrine

In American foreign policy, a new motto: Don't ask. Tell

FOR EIGHT YEARS THE CLINTON ADMINISTRATION preached the need for exquisite sensitivity to the Russians. They'd had a rough time. They needed nurturing from their new American friends.

They got it. We fed them loans, knowing that much of the money would disappear corruptly. We turned away from atrocity in Chechnya lest we weaken the new Russian state. But most important, we went weak in the knees on missile defense. The prospect of American antiballistic missiles upset the Russians. And upsetting the Russians was something we simply were not to do.

The Russians cannot keep up with American technology. And they fear that an American missile shield will render obsolete their last remnant of greatness: their monster, nuclear-tipped missiles. So they insist that we adhere to a 1972 treaty signed with the defunct Soviet Union that prohibited either side from developing missile defenses. That the treaty is obsolete—it long predates the world of rogue states racing to acquire missile-launched weapons of mass destruction—does not concern the Russians. Withdraw from the treaty, they said, and you have destroyed the "strategic stability" on which the peace of the world depends.

The Clinton Administration took that threat seriously—so seriously that for eight years it equivocated on building an American ABM system. Finally, President Clinton promised to decide by June 2000. Come June, he punted.

Eight years, and no defense. But the bear was content.

Bear contentment was never a high priority for Ronald Reagan. He offered a different model for dealing with the Russians. The '80s model went by the name of peace through strength. But it was more than that. It was judicious but unapologetic unilateralism. It was willingness—in the face of threats and bluster from foreign adversaries and nervous apprehension from domestic critics—to do what the U.S. needed to do for its own security. Regardless.

It was Reagan who famously proposed a missile shield, and even more famously refused to barter it away at the Reykjavik summit, an event many historians consider the turning point in the cold war. That marked the beginning of the Soviets' definitive realization that they were going to lose the arms race to the U.S.—and that neither threats nor cajoling could dissuade the U.S. from running it.

This decade starts with a return to the unabashed unilateralism of the '80s. It began last year with a speech by George W. Bush proposing that the U.S. build weapons to meet American needs—and not to accommodate the complaints or gain the agreement of other countries. For 40 years the U.S. would not cut its offensive nuclear missiles except in conjunction with Soviet cuts. Bush's refreshing question was: Why? We don't need Russians cutting *our* offensive weapons through arms-control treaties. And we don't need Russians telling us whether or not to build defensive weapons.

This was the genesis of the Bush Doctrine, now taking shape as the Administration takes power. Its motto is, We build to suit—ourselves. Accordingly, the President and the Secretary of Defense have been unequivocal about their determination to go ahead with a missile defense.

They staked their claim. And what happened? Did the sky fall, as the Clinton Russia experts warned? On the contrary. Convinced at last of American seriousness, the Russians immediately acquiesced. After just one month of Bush, Moscow has come forward with its very own missile-defense plan. The fact that it is not well sketched out and that it is in part designed to split the U.S. off from Europe is beside the point. The Russians have responded, as did the Soviets before them, to American firmness. Faced with reality, they accommodate to it.

Reviewing the troops with Defense Secretary Donald Rumsfeld

Who defines reality: there lies the difference between this Administration and the last. Clinton let Russian opposition define reality. Bush, like Reagan, understands that the U.S. can reshape, indeed remake, reality on its own.

In the liberal internationalist view of the world, the U.S. is merely one among many—a stronger country, yes, but one that has to adapt itself to the will and the needs of "the international community." That is why the Clinton Administration was almost manic in pursuit of multilateral treaties—on chemical weapons, biological weapons, nuclear testing, proliferation. No matter that they could not be enforced. Our very signing would show us to be a good international citizen.

This is folly. America is no mere international citizen. It is the dominant power in the world, more dominant than any since Rome. Accordingly, America is in a position to reshape norms, alter expectations and create new realities. How? By unapologetic and implacable demonstrations of will.

Russia did not see the light on missile defense. It saw the future, as defined by the U.S., and decided to join it. ■

NEED FOR SPEED

Methamphetamine has become Asia's drug of choice. Our writer reports on the culture of speed—and recounts his own addiction

By KARL TARO GREENFELD BANGKOK

JACKY TALKS ABOUT KILLING HIM, SLITTING his throat from three till nine and hanging him upside down so the blood drains out of him the way it ran from the baby pigs they used to slaughter in her village before a funeral feast. He deserves it, really, she says, for his freeloading, for his hanging around, for how he just stands there, spindly-legged and narrow-chested and pimple-faced with his big yearning eyes, and just begs for another hit.

She has run out of methamphetamine, what the Thais call *yaba* (mad medicine), and she has become agitated and irritable and potentially violent. Jacky's cheeks are sunken, her skin is pockmarked and her hair is an unruly explosion of varying strands of red and brown. She is tall and skinny and her arms and legs extend out from her narrow torso with its slightly protuberant belly almost like the appendages of a spider who got shortchanged on legs.

UP IN SMOKE: Bingeing in a Bangkok hovel, Jacky and her friend Nong share a tablet of meth, called *yaba* or mad medicine

Photographs for TIME by Jonathan Taylor

Sitting on the blue vinyl flooring of her Bangkok hut, Jacky leans her bare back against the plank wall, her dragon tattoos glistening with sweat as she trims her fingernails with a straight razor. It has been two days—no, three—without sleep, sitting in this hut and smoking the little pink speed tablets off sheets of tinfoil stripped from Krong Tip cigarette packets. Now, as the flushes of artificial energy recede and the realization surfaces that there's no more money anywhere in this hut, Jacky is crashing hard and she hates everyone and everything. Especially Bing. She hates that sponging little punk for all of the tablets he smoked a few hours ago—tablets she could be smoking right now. Back then, she had a dozen tablets packed into a plastic soda straw stuffed down her black, wire-frame bra. The hut was alive with the chatter of a half dozen speed addicts, all pulling apart their Krong Tip packs and sucking in meth smoke through metal pipes. Now that the pills are gone, the fun is gone. And Bing, of course, he's long gone.

This slum doesn't have a name. The 5,000 residents call it Ban Chua Gan, which translates roughly as Do It Yourself Happy Homes. The expanse of jerry-rigged wood-frame huts with corrugated steel roofs sprawls in a murky bog in Bangkok's Sukhumvit district, in the shadow of 40-story office buildings and glass-plated corporate towers. The inhabitants migrated here about a decade ago from villages all around Thailand. Jacky came from Nakon Nayok, a province near Bangkok's Don Muang airport, seeking financial redemption in the Asian economic miracle. And for a while in the mid-'90s, conditions in this slum actually improved. Some of the huts had running water piped in. Even the shabbiest shanties were wired for electricity. The main alleyways were paved. This was when Thailand's development and construction boom required the labor of every able-bodied person. There were shopping malls to be built, housing estates to be constructed, highways to be paved. And someone had to service those office buildings and corporate towers.

SELLING HAPPINESS: A meth dealer in Bangkok's Bang Khet ghetto shows off his wares. *Yaba* sells for $1.20 a pill

Around the same time, mad medicine began making its way into Do It Yourself Happy Homes. It had originally been the drug of choice for long-haul truck and bus drivers, but during the go-go '90s, it evolved into the working man's and woman's preferred intoxicant, gradually becoming more popular among Thailand's underclass than heroin and eventually replacing that opiate as the leading drug produced in the notorious Golden Triangle. While methamphetamines had previously been sold either in powdered or crystalline form, new labs in Burma and northern Thailand commoditized the methamphetamine business by pressing little tablets of the substance that now retail for about 50 baht ($1.20) each. At first, only bar girls like Jacky smoked the stuff. Then some of the younger guys who hung out with the girls tried it. And then a few of the housewives began smoking, and finally some of the dads would take a hit or two when they were out of corn whiskey. Now it has reached the point that on weekend nights, it's hard to find anyone in the slum who isn't smoking the mad medicine.

When the *yaba* runs out after half the slum's population has been up for two days bingeing, most of the inhabitants feel a bit like Jacky, cooped up in her squalid little hut, her mouth turned up into a vicious little scowl and her eyes squinted and empty and mean. She looks like she wants something. And if she thinks you have what she wants, then look out. She slices at her cuticles with the straight razor. And curses Bing.

But then Bing comes around the corner between two shanties and down the narrow dirt path to Jacky's hut. He stands looking lost and confused, as usual. Jacky pretends he's not there. She sighs, looking at her nails, and stage whispers to me that she hates him.

Bing, his long black hair half-tied into a ponytail, stands next to a cinder-block wall, rubbing his e[illegible]. Over his head, a thick trail of red army ants runs between a crack in the wall and a smushed piece of pineapple. He reaches into his pocket and pulls out a tissue in which he has wrapped four *doa* (bodies, the slang for speed tablets). Jacky stops doing her nails, smiles and invites Bing back into her hut, asking sweetly: "Oh Bing, where have you been?"

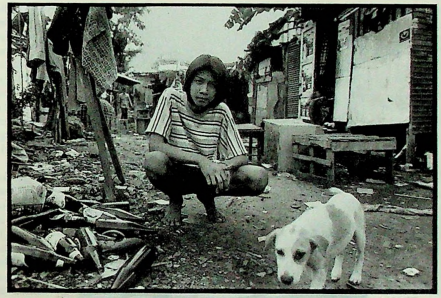
This mad medicine is the same drug that's called *shabu* in Japan and Indonesia, *batu* in the Philippines and *bingdu* in China. Perhaps it's appropriate that speed is Asia's drug of choice, with an estimated 30 million users across the region. Hard work remains this part of the world's indomitable virtue. Making money and getting rich are viewed as glorious ends in themselves, no matter the means. And methamphetamine use, at first, dovetails nicely with those 16-hour days slaving on a construction site or hunched over a workstation. It is the perfect drug for those struggling to keep pace with an upwardly mobile continent.

While it has taken scientists years to figure out the clinical pharmacology and neurological impact of ecstasy and other designer drugs like ketamine, methamphetamines are a blunt pharmaceutical instrument. The drug encourages the brain to flood the synapses with the neurotransmitter dopamine—the substance your body uses to reward itself when you, say, complete a difficult assignment at the office or finish a vigorous workout. And when the brain is awash with dopamine, the whole cardiovascular system goes into sympathetic overdrive, increasing your heart rate, pulse and even your respiration. You become, after that first hit of speed, gloriously, brilliantly, vigorously awake. Your horizon of aspiration expands outward, just as in your mind's eye your capacity for taking effective action to achieve your new, optimistic goals has also grown exponentially. Then, eventually, maybe in an hour, maybe in a day, maybe in a year, you run out of speed. And you crash.

In country after country throughout Asia, meth use skyrocketed during the '90s. And with the crash of the region's high-flying economies, the drug's use has surged again as battered, tired populations try to work through their hangovers with even more mad medicine. If you used the drug to push yourself to work harder when the region was on its way up, you then used it to alleviate the boredom of unemployment when the region was on its way down. It has now become a continent-wide crisis, one that is creating millions of addicts and threatening to cripple societies barely on the mend from an economic cataclysm and still wrestling with huge numbers of addicts [illegible]ked on more traditional drugs like heroin. The numbers reveal a region with an increasingly lethal need for speed: in Japan, between 1995 and 1999, the amount of methamphetamine seized, a pretty good indicator of usage patterns, increased from 85 kg to nearly 2,000 kg—about 65 million hits. The story is the same in South Korea, where there are now more than 7,000 meth-related arrests annually, up from just [illegible] in 1992. In Indonesia, 218 kg of *shabu* were seized in 1999, up from just 3 kg two years earlier. The amount of ice confiscated in China doubled in 1999 and then doubled again last year to 20.9 tons. In Taiwan, speed now accounts for 85% of all drugs seized; in Cambodia, police seized 35,000 amphetamine tablets last year, up from 22,000 in 1999. And in Thailand, the government estimates that an astounding 800 million *yaba* tablets were imported and consumed last year—enough for every man, woman and child in the country to smoke a dozen each. A U.S. Drug Enforcement Administration agent who has worked in Asia for many years warns: "The opium war may be nothing compared to the Asian meth war."

The base of the drug—ephedrine—was actually first synthesized in Asia: a team of Japanese scientists derived it from the Chinese *mao* herb in 1892. Amphetamine and methamphetamine are derived from this ephedrine base, or from pseudoephedra, an artificial alternative, in a hazardous process that involves heating and pressurizing solvents and other store-bought chemicals. While the refining can be volatile, it is not terribly complex, which means that meth labs are an ideal family business for industrious Asians, who set them up in converted bathrooms, farmhouses or even the family hearth. Unlike ecstasy, which requires sophisticated chemical and pharmaceutical knowledge to manufacture, or heroin, where the base product, the poppy plant, is a vulnerable crop, there are no limits to how much meth can be made or who can make it.

This gray-brick warehouse on the outskirts of Beijing is a typical, small-time meth lab. Here, the six members of the Li family oversee the process of creating crystalline methamphetamine. Their neighbors, says father Li, think they are making legal chemicals, which is why crystals are drying out in the open between two warehouses. "No one knows that this isn't an agricultural product," he smiles. "No one knows what methamphetamines look like." After Li's speed is processed it is handed over to local crime gangs, who ship it to Japan, Taiwan, Indonesia and Australia or take it overland into Burma to the Wa state, where the drugs are further refined into the tablets that are eventually smuggled into Thailand and sold, via numerous middlemen, to Jacky and her fellow addicts at the Do It Yourself Happy Homes. The pink pills that Jacky smokes are all stamped WY, the symbol of the United Wa State Army.



HOUSE ARREST: Bing won't leave his row of huts for fear of being picked up by the police. He says he is so skinny that everyone will know he's a *yaba* addict

THERE IS SOMETHING familiar about Jacky and her little hut and her desperate yearning for more speed and even for the exhilaration and intoxication she feels when she's on the pipe. Familiar to me because I've been there before. Not in this exact room nor with these people. But I've been on speed.

During the early '90s, I went through a period when I was smoking *shabu* with a group of friends in Tokyo. I inhaled the smoke from smoothed-out tinfoil sheets folded in two, holding a lighter beneath the foil so that the shards of *shabu* liquefied, turning to a thick, pungent, milky vapor. The smoke tasted like a mixture of turpentine and model glue to this day. I can't smell paint thinner without thinking of smoking speed.

The drug was euphorically powerful, convincing us that we were capable of anything. And in many ways we were. We were all young, promising, on the verge of exciting careers in glamorous fields. There was Trey, an American magazine writer, like myself, in his 20s; Hiroko, a Japanese woman in her 30s who worked for a Tokyo woman's magazine; Delphine, an aspiring French model and Miki, an A. and R. man for a Japanese record label. When we

"I can stop my speed, but I can never stay stopped." 75

would sit down together in my Nishi Azabu apartment to smoke the drug, our talk turned to grandiose plans and sure-fire schemes. I spoke of articles I would write. Delphine talked about landing a job doing a Dior lingerie catalog. Miki raved about a promising noise band he had just signed. Sometimes the dealer, a lanky fellow named Haru, would hang around and smoke with us and we would be convinced that his future was surely just as bright as all of ours. There was no limit to what we could do, especially if we put our speed-driven minds to work.

It's always that way in the beginning: all promise, potential, fun. The drug is like a companion telling you that you're good enough, handsome enough and smart enough, banishing all the little insecurities to your subconscious. And you bid them good riddance, because in your giddiness you feel liberated from those self-doubts—never mind that they are there for a reason, to remind you that you are vulnerable, that you are human. You feel totally, completely alive.

I don't know that it helped me to write better stories; I don't believe meth really helps you in any way at all. But in those months, it became arguably the most important activity in my life. Certainly it was the most fun. And I looked forward to Haru coming over with another 20,000-yen baggie of *shabu*, the drug resembling a little, oily lump of glass. Then we would smoke, at first only on weekends but soon we began to do it on weekdays, whenever I had a free evening. At first only with my friends. Then sometimes I smoked alone. Then mostly alone.

HOLD ON: Big loves his bike and speeding on it. Weekends go up in meth and exhaust fumes racing in Klong Toey

NOT EVERYONE IN JACKY'S NEIGHborhood is as badly off as Jacky and Bing. And even the slum has its nicer alleys, where the huts are made of finished wood and there are flush toilets and the skittering rats don't root through piles of festering garbage. The teens and twenty-somethings in these parts of the slum also like to smoke *yaba*, but they look down upon Jacky and Bing and their flagrant, raging addictions. Sure, the cool guys in the neighborhood, guys like Big, with a shaved head, gaunt face and sneering upper lip, drop into Jacky's once in a while to score some drugs. Or they'll buy a couple of tablets from Bing's mother, who deals. But they tell you they're different from Bing and the hard-core users. "For one thing," Big alibies, "Bing's selfish. That's how people get when they smoke too much *yaba*. He loves himself because he's high all the time."

For another, Big points out, Bing hasn't left the slum neighborhood in a year. He doesn't work. He doesn't do anything but smoke. (Bing just shrugs when I ask if it's true that he hasn't left in a year. "I'm too skinny to leave," he explains, "everyone will know I'm doing *yaba*.") Big has a job as a pump jockey at a Star gas station. And he has a girlfriend, and he has his motorcycle, a Honda GSR 125, and this weekend, like most weekends, he'll be racing his bike with the other guys from the neighborhood, down at Bangkok's supersium Klong Toey. That's why tonight, a few days before the race, he is working on his bike, removing a few links of the engine chain to lower the gear ratio and give the bike a little more pop off the line. He kneels down with a lit candle next to him, his hands greasy and black as he works to reattach the chain to the gear sprockets. Around him a few teenage boys and girls are gathered, smoking cigarettes, some squatting on the balls of their feet, their intent faces peering down at scattered engine parts. The sound is the clatter of adolescent boys. Whether the vehicle in question is a '65 Mustang or a '99 Honda GSR motorcycle, the posturing of the too-cool motorhead trying to goose a few more horsepower out of his engine while at the same time look bitchin' in front of a crowd of slightly younger female spectators is identical, whether you are in Bakersfield or Bangkok.

The slang for smoking speed in Thai is *keng rot*, literally racing, the same word used to describe the motorcycle rallying the boys do every weekend. Their lives revolve around these two forms of *keng rot*. They look forward all week to racing their bikes against other gangs from other neighborhoods. And while they profess to have nothing but disgust for the slum's hard-core addicts, by 4 a.m. that night, in Big's room in his parent's house, on a mattress laid on the floor next to his beloved Honda, Big and his friends are smoking *yaba* and there suddenly seems very little difference between his crowd and Jacky's. "Smoking once in a while, on weekends, that really won't do any harm," Big explains, exhaling a plume of white smoke. "It's just like having a drink." But it's Thursday, I point out. Big shrugs, waving away the illogic of his statement, the drug's powerful reach pulling him away from the need to make sense. He says whatever he wants now, and he resents being questioned. "What do you want from me? I'm just trying to have fun."

The younger neighborhood kids who look up to Big are running out every half hour to buy more speed. They'll keep on racing until dawn when the money is finally gone.

In Jacky's hut, Bing and a few bar girls are seated with their legs folded under them, taking hits from the sheets of tinfoil. As Jacky applies a thick layer of foundation makeup to her face, and then dabs on retouching cream and then a coating of powder, she talks about how tonight she has to find a customer; she needs to make a thousand baht. She'll work the dance floor at Angel's and, if she can't pick up a foreigner, she'll try Thermae, a sleazy after-hours joint and the evening's last resort for Bangkok's bar girls. If she can find a customer and save some money, she can visit her children out in Nakon Nayok. Her two daughters and nine-year-old son live with her uncle. Jacky sees them once a month, and she talks about how she likes to bring them new clothes and cook for them. When she talks about her kids, her almond-shaped eyes widen. "I used to dream of opening a small shop, like a gift shop or a 7-Eleven. Then I could take care of my children and make money. I used to dream about it all the time, and I even believed it was possible, that it was just barely out of reach."

Back then, she was a motorbike messenger, shuttling packages back and forth throughout Bangkok's busy Chitlom district. She was laid off after the 1997 devaluation of the baht when her company released those messengers who didn't own their own motorbikes. "Now I don't think about the gift shop anymore. Smoking *yaba* pushes those kinds of thoughts, and the thoughts about my children, to the back of my mind. It's good for that. Smoking means you don't have to think about the hard times." Bing nods his head, agreeing. "When I smoke, it makes everything seem a little better. I mean, look at this place, how can I stop?"

SPEED RACERS: *Keng rot*, literally racing, is Thai slang for smoking meth. The same word is used for the motorcycle rallies that screech through the streets of Bangkok's worst slums

Bing's mother, Yee, slips off her sandals as she steps into the hut, clutching her 14-month-old baby. She sits down next to her son and while the baby scrambles to crawl from her lap, she begins pulling the paper backing from a piece of tinfoil, readying the foil for a smoke. Her hands are a whir of finger-flashing activity—assembling and disassembling a lighter, unclogging the pipe, unwrapping the tablets, straightening the foil, lighting the speed and then taking the hit. She exhales finally, blowing smoke just over her baby's face. Bing asks his mother for a hit. She shakes her head. She doesn't give discounts or freebies, not even to her own son.

At one point I ask Yee if she ever tells Bing he should stop smoking *yaba*. "I tell him he shouldn't do so much, that it's bad for him. But he doesn't listen."

Perhaps she lacks credibility, since she smokes herself?

"I don't smoke that much," she insists.

"She's right," Bing agrees. "Since she doesn't smoke that much, I should listen to her."

"And he's only 15 years old," Yee adds.

Bing reminds her he's 17.

"I don't know where the years go," Yee says, taking another hit.

FOR THE COUNTRIES AT THE FRONT LINES OF THE METH WAR, trying to address the crisis with tougher enforcement has had virtually no effect on curtailing the numbers of users or addicts. Asia has some of the toughest drug laws in the world. In Thailand, China, Taiwan and Indonesia, even a low-level drug trafficking or dealing conviction can mean a death sentence. Yet *yaba* is openly sold in Thailand's slums and proffered in Jakarta's nightclubs, and China's meth production continues to boom. Even Japan, renowned for its strict anti-drug policies, has had virtually no success in stemming speed use and abuse. "The drug situation is so serious right now that the Prime Minister himself is heading the anti-drug task force," says Yoshitaka Yamada, superintendent of the National Police Agency's Drug Enforcement Divison. Even so, Japan has been fighting this battle longer than most Asian countries and has never been able to eradicate or even seriously dent its methamphetamine culture. "The Japanese like stimulants because it suits their hard-working character," explains Yamada. Certainly, today, amphetamines are more widely available in districts like Tokyo's Shinjuku or Osaka's Nishinari than ever before.

In Taiwan, Dr. Lin Shih-ku, director of the Taipei City Psychiatric Center's department of addiction science, estimates there are 200,000 addicts, or about 1% of the population; in Thailand there are an estimated 2 million speed addicts; in Indonesia the numbers could be even more appalling, though no accurate figures exist.

Without any sort of outside help or intervention, quitting the drug becomes arduously difficult. Especially since prolonged use can lead to severe psychosis. "Basically," says Dr. Lin, "they go crazy." In the meantime, for societies grappling with this crisis, many debilitating side effects result from hosting large addict populations, including spiking crime rates, larger numbers of absentee fathers, higher HIV infection rates and increasing domestic abuse. Undoing the damage could take the rest of the decade, and if the American experience of fighting a prolonged battle against drugs is any example, the war may never be totally won. More likely, these countries and societies will have to write off vast swaths of their populations as drug casualties, like the American victims of the '80s crack epidemic.

"Smoking *yaba* means you don't have to think about the hard times."

Asia's medical and psychiatric infrastructure is already being overwhelmed by the number of drug addicts, particularly meth abusers, who are crashing and seeking help. But in most of the region, counseling facilities are scarce and recovery from drug addiction is still viewed as a matter of willpower and discipline rather than a tenuous and slow spiritual and psychological rebuilding process. When it comes to methamphetamine addiction, where the brain goes through physiological changes that leave the abstinent addict clinically depressed because of depleted serotonin levels, recovery programs and rehab centers become a crucial way station between addiction and sobriety. But most of the region's drug-treatment centers are run like a cross between military-style boot camps and prisons. Even so, beds are scarce as addicts seek the meager resources available. In China, the nearly 750 state-run rehab centers are filled to capacity; in Thailand the few recovery centers suffer from a chronic shortage of staff and beds. While the most powerful tools for fighting addiction in the West—12-step programs derived from Alcoholics Anonymous—are available in Asia, their dissemination and implementation do not reach much of the region. In Thailand, for example, Narcotics Anonymous meetings are far more common in English than in Thai. But it is precisely these sorts of support groups that can determine whether an addict can stay away from speed. "On good days, I am two people," says Cai Zhoushen, a speed addict who has been sent to a Kunming rehab center three times. "One who wants to quit speed and one who wants to just have it one more time."

Or, as Bing puts it: "I can stop using speed anytime I want, but I can never stay stopped."

WORKING WOMAN: Jacky at a Bangkok nightclub, seeking a foreign client who will pay her the 1,000 baht she needs. She says the money is for her kids; most of it goes to speed

WHAT STARTED OUT AS A FUN DIVERSION FOR ME AND MY TOKYO crowd degenerated in a few months into the kind of chronic drug use that Jacky and her crowd have found familiar. I began to smoke alone, and I started smoking before going out on interviews or to meet editors. I smoked, basically, to begin my days. In the evening, I'd take valiums or halcyons or cercines or any of a number of sedatives to help me calm down. When I stopped smoking for a few days just to see if I could, a profound depression would come over me. The drab grayness of the world would become crushing and the boredom would seem ineluctable. Nothing seemed fun. Nothing seemed worthwhile. Every book was tortuously slow. Every song was criminally banal. Every movie crawled. The sparkle and shine had been sucked out of life so completely that my world came across as some fluorescent-lit, decolorized, saltpetered version of the planet I had known before. And my own prospects? Absolutely dismal. I would sit in that one-bedroom Nishi Azabu apartment and consider this sorry career I had embarked upon, these losers I associated with compounding the very long odds that I would ever amount to anything. It really seemed there was no hope, that I was destined to become this shabbily dressed, dull mediocrity, short on wit, lacking talent, unable to muster the power or engines for sustained flight.

These feelings, about the world and my life, seemed absolutely real. I could not tell for a moment that this was a neurological reaction brought on by the withdrawal of the methamphetamine. My brain had stopped producing dopamine in normal amounts because it had come to rely upon the speed kicking in and running the show. Researchers now report that as much as 50% of the dopamine-producing cells in the brain can be damaged after prolonged exposure to relatively low levels of methamphetamine. In other words, the depression is a purely chemical state. Yet it feels for all the world like the result of empirical, clinical observation. And then, very logically, you realize there is one, surefire solution, the only way to feel better: more speed.

I kept at that cycle for a few years and started taking many more drugs than just methamphetamine, until I hit my own personal bottom. I spent nearly six weeks in a drug treatment center, sitting through tedious group therapy sessions, working out some plan for living that didn't require copious amounts of methamphetamines or tranquilizers. I left rehab five years ago. I haven't had another hit of *shabu*—or taken any drugs—since then. But I am lucky; I am an exception. Of that crowd who used to gather in my Tokyo apartment, I am the only one who has emerged clean and sober. Trey, my fellow magazine writer, never really tried to quit and now lives back at home with his aging parents. He is nearly 40 years old, still takes speed—or ritalin or cocaine or whichever uppers he can get his hands on—and hasn't had a job in years. Delphine gave up modeling after a few years and soon was accepting money to escort wealthy businessmen around Tokyo. She finally ended up working as a prostitute. Hiroko did stop taking drugs. But she has been in and out of psychiatric hospitals and currently believes drastic plastic surgery is the solution to her problems. Miki has been arrested in Japan and the U.S. on drug charges and is now out on parole and living in Tokyo. And Haru, the dealer, I hear he's dead.

Despite all that I know about the drug, despite what I have seen, I am still tempted by it. The pull of the drug is tangible and real, almost like a gravitational force compelling me to want to use it again. To feel just once more the rush and excitement and the sense, even if it's illusory, that life does add up, that there is meaning and form to the passing of my days. Part of me still wants it.

AT 2 A.M. ON A SATURDAY, BIG AND HIS FELLOW BIKERS FROM THE Do It Yourself Happy Homes are preparing for a night of bike racing by smoking more *yaba* and then, as if to get their 125-cc bikes in a parallel state of high-octane agitation, squirting STP performance goo from little plastic packets into their gas tanks. The bikes are tuned up and the mufflers are loosened so that the engine revving at full throttle sounds like a chain saw cutting bone: splintering, ear-shattering screeches that reverberate up and down the Sukhumvit streets. The bikers ride in a pack, cutting through back alleys, running lights, skirting lines of stalled Bangkok traffic, slipping past each other as they cut through the thick city smog. This is their night, the night they look forward to all week during boring mornings at school or dull afternoons pumping gas. And as they ride massed together, you can almost feel the surge of pride oozing off of them, intimidating other drivers to veer out of their way, even truckers hitting the brakes as the gang roars past.

REST FOR THE WEARY: After three sleepless days high on *yaba*, Jacky's bar-girl friends crash in the hut. Coming down from speed induces a depression that leaves users craving more

On Na Ranong avenue next to the Klong Toey slum, they meet up with hundreds of other bikers from other slums like Makasan and Suan Phloo. They have been holding these rallies for a decade, some of the kids first coming on the backs of their older brother's bikes. *Ken rot* is a ritual by now, as ingrained in Thai culture as the speed they smoke to get up for the night of racing. The street is effectively closed off to non-motorcyclists and pedestrians. The bikers idle along the side of the road and then take off in twos and threes, popping wheelies, standing on their seats; the tricks are really third-rate motorcycle stunts, the kind you might see in a local 4th of July parade in the U.S. What is impressive is the speed at which the stunts are executed. Souped up and fitted with performance struts and tires, these bikes accelerate at a terrifying rate if you're on the back of one of them. And that blast off the line makes for an unstable and dangerous ride. It is the internal combustion equivalent of *yaba*: fast, fun, treacherous. And certain to result, eventually, in a fatal spill. But if you're young and Thai and loaded on mad medicine, you feel immortal and it doesn't occur to you that this night of racing will ever, really, have to end. The hundreds of bikers thronged on the street, the revving engines, the other kids cheering as you make your runs, even the cops coming and setting off concussion grenades and then chasing you through the narrow alleys of Klong Toey. It's all so exciting, euphoric and fun you just never think there's any downside.

There are still moments when even hard-core addicts like Jacky can recapture the shiny, bright exuberance of the first few times she tried speed. Even tonight, as she dances with a potential Belgian client at Angel's, and it looks like the customer is about to take her back to his hotel room, and she's thinking that she'll soon have enough money to visit her children, it doesn't seem so bad. It seems life is almost manageable. A few more customers and who knows, maybe one will really fall for her and pay to move her to a better neighborhood, to rent a place where even her children could live. Maybe she could even open that convenience store after all.

By the next afternoon, however, all the promise of the previous evening has escaped from the neighborhood like so much exhaled smoke. Jacky's customer lost interest and found another girl. Even the bike racing fell apart after the cops broke up the first few rallying points. And now, on a hazy, rainy Sunday, Jacky and a few of the girls are back in her hut. They're smoking, almost desperately uploading as much speed as possible to ward off this drab day and this squalid place.

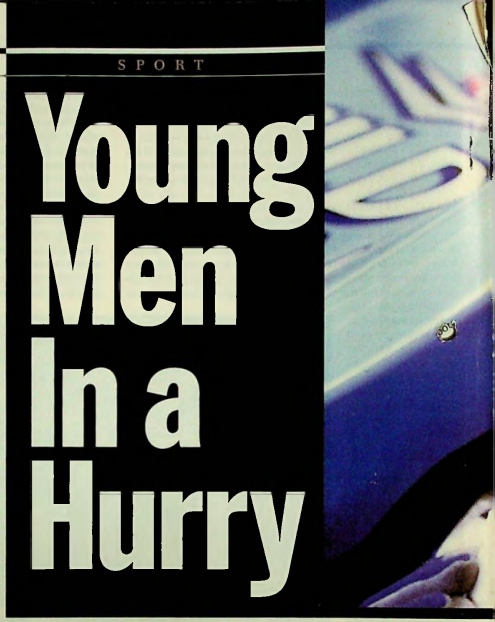
Jacky pauses as she adjusts the flame on a lighter. "Why don't you smoke?" she asks me.

She tells me it would make her more comfortable if I would join her. I'm standing in the doorway to Jacky's hut. About me are flea-infested dogs, puddles of stagnant water several inches deep with garbage, and all around is the stench of smoldering trash. The horror of this daily existence is tangible. I don't like being in this place, and I find depressing the idea of living in a world that has places like this in it. And I know a hit of the mad medicine is the easiest way to make this all seem bearable. Taking a hit, I know, is a surefire way of feeling good. Right now. And I want it.

But I walk away. And while I hope Jacky and Bing and Big can one day do the same, I doubt they ever can. They have so little to walk toward. —*With reporting by Hannah Beech/Beijing, Macabe Keliher/Taipei and Sachiko Sakamaki/Tokyo*

"Smoking once in a while won't do any h, it's just like having a drink."

Young Men In a Hurry



Too fast to be denied, a new band of motor racing prodigies are taking their places on the grid, confounding Formula One's old guard

By TIM BLAIR

SCHOOLBOY LEWIS HAMILTON is a dutiful student. His grades in maths and English have always been high, and this year the 15-year-old from Hertfordshire, England, expects an A in French. Typical of many boys, Lewis dreams of becoming a Formula One driver; he has a collection of Grand Prix videos and reads car racing magazines. In Hamilton's case, however, these are just as much study guides as his algebra and language textbooks. In 1998 Hamilton, a champion racer of tiny, motorcycle-engined go-karts, signed a contract with Formula One powerhouse McLaren to shape and develop his racing career. He has been headed for the 340-km/h world of Formula One since he was just 13.

Hamilton is among the youngest of a battalion of youthful speedsters who are charging at F1's gates. Some have already burst through: this Sunday in Melbourne, Australia, 19-year-old Fernando Alonso will compete in an F1 Grand Prix race for the first time, alongside 21-year-olds Jenson Button and Kimi Raikkonen, and Enrique Bernoldi, 22. The sport has seen young drivers before, but never in such numbers or depth. "They've livened it up, haven't they?" says Jim Warren, whose junior formula cars have been piloted in British races by Raikkonen and Button. While F1 teams queue to throw money at the best of the new talent—BMW-Williams contracted Button for $660,000 before he'd driven the first race in his debut season last year—some senior F1 figures fear the "baby racers" may liven up the sport too much. "When there is a major accident caused by the presence of very inexperienced drivers in F1," complained Max Mosley, president of F1's ruling body, the Fédération Internationale de l'Automobile, "I'm the one who will have to explain it to the media."

Mosley's main worry leading up to the Australian Grand Prix is Raikkonen, a former kart champ with only 18 months' experience racing cars. Swiss F1 team Sauber signed Raikkonen for the 2001 season after noting the Finn's astonishing speed in junior racing, but the FIA—citing rules that require demonstrated expertise in lesser cars—balked at awarding a permit (called a superlicense) that would allow Raikkonen to compete. In December, Raikkonen drove flat out for hours at Spain's Jerez circuit while 25 members of the FIA commission, made up of F1 teams, sponsors, manufacturers, promoters and tire makers, looked on. His superlicense was granted by a vote of 24 to 1. The only "no" vote came from Mosley, who told the London *Times* the decision was "irresponsible and potentially dangerous."

The FIA president isn't alone in his concerns. Jaguar driver Eddie Irvine was dismissive of Raikkonen's test, and of subsequent rapid times the Finn set during practice in fine weather. "It's all well testing in sunshine," he said. Button, after competing in only 17 F1 races himself, surprised F1 observers by saying the Finn "may have difficulties competing on a packed grid. It is a big step up and he will have to be careful." Even schoolboy Hamilton is dubious. Raikkonen, he says, "is making a big mistake."

Raikkonen's learning curve looks more like a sheer ascent. Last year he drove a Formula Renault powered by a puny four-cylinder, 170-horsepower engine. This year he'll drive a Sauber propelled by a 10-cylinder Ferrari engine that produces more than 800 hp. and is slowed by crushingly effective carbon-fiber brakes; the 160-kg vehicle can catapult from zero to 160 km/h and back to zero in four frantic seconds. The gigantic forces generated during races chew through a complete set of tires every 100 km and maul drivers. Raikkonen may be talented, says former F1 driver Chris Amon, but his "pretty minimal" racing background simply can't prepare him for the ordeal of controlling an F1 car in close company.

In 1963, when Amon was one month short of his 20th birthday, he became the youngest man ever to race in F1 (there

KARNATTAKA POSSIBLE

STATE LEVEL CONSULTATION ON SOLUTION TO ALCOHOL RELATED PROBLEMS

Consultation
Goal
objectives
Strategies
Plan of Action.
Methodology
Introduction
Interventions
- Experiences

Although alcohol consumption has existed in India for many centuries, the quantity, pattern of use and resultant problems have undergone substantial changes over the past 20 years. These developments have raised concern about the public health and social consequences of excessive drinking. In recent years it has been alarmingly increasing and created high level effect on the socio-economic and health areas in the Indian community.

Chakravarthy (1990) reported alcohol use to be from 26% to 50% among rural southern Indian males, and the prevalence was higher among those of lower socio economic status and illiterate. Mohan etal (1979) found that 12.7% high school students were drinking alcohol. Dube etal (1978) found the prevalence of ever having used alcohol among university students was 31.6% medical students have shown a higher drinking prevalence of from 40% to 60% (sethi and Manchanda). Now we could imagine the level of increase during the pup culture period of last one decade.

Obviously everybody knows the effects of alcohol consumption on :
HEALTH including accidents and psychiatric disorders,
Family,
Workplace,
Violence and Crime and
Economics.

NIMHANS found out that one of the main reason for the highest suicide rate of Bangaloreans would be alcoholism and of the farmers who committed suicide also alcoholics.

Current Responses
Legislation and policy

India is one of the rare countries where prohibition has been incorporated into the national constitution as one of the directive principles of sate policy. Article 47 of the constitution of India reads that "the state shall endeavor to bring about prohibition of the consumption except for medicinal purpose of intoxicating drinks and of drugs which are injurious to health". Alcoholic beverage production and sales is controlled by the states, not the federal government, with a result that there are different, often contractory, policies among all the 29 states. Most of the states promoted the production and sale of alcohol, fulfilling the constitutional requirement of prohibition by token sypolic measures such as designating some days in the year as "dry days".

The main reason for ignoring the constitutional prohibition is the large amount of revenue that the state government derived from alcoholic beverages. The proportion of revenue from alcohol is considerable, with some states obtaining as much as 10% of their total revenues from their source. Alcohol producers and retailers also have lobbies to maintain policies favorable to them, using their money and political clout to get their way.

Alcoholism
Primary Prevention
Management
Rehabilitation

Beyond the rather drastic step of prohibition, governments have a number of other policy options at their disposal to reduce alcohol consumption and alcohol related problems, but these are not used in any meaningful way. Laws ban the sale of alcohol to minors ,but they are not strictly enforced. Retail licenses are granted increasingly by open auction, thus fetching a high price. This in turn, forces retailers in to promotional activities so as to increase their sales and profits. Licenses for the production of beverages alcohol, especially beer, are now granted in large numbers. Public drinking is banned, but action usually is not taken against attenders unless a fight breaks out. One powerful tool governments have is the tax levied an alcohol beverages, which eventually affects retail price and therefore consumption levels. The actual price of beverage alcohol in most of India has decreased in real terms over the last twenty years Government have resisted tax increase an alcohol in order to maximize their revenues from higher sales.

A health warning printed on alcohol containers is mandatory and this legal provision is followed. But such warning are no help to the large proportion of illiterate consumers who can not read them. No units or other measures of alcohol are mentioned on the containers. Liquor advertisements are banned from the print and electronic media, but liquor companies have found ways to get around these rules, including surrogate advertising, sponsorship of sports and other events, and satellite television. The net result is a consistent level of high pressure promotion of premium and middle sector beverages.

Driving a vehicle with a blood alcohol level of more than 100 mg percent is a crime, but lack of proper measuring equipment assures that only the obviously drunk one caught.

In recent years the Indian government has relaxed rules concerning alcoholic beverage imports, along with those for the local production of foreign brands under collaboration agreements. This has provided an unprecedented opportunity for multinational alcohol producers to establish themselves in india. Not only is this likely to increase alcohol sales in India, but it also will give Western style drinking even more social legitimacy and a more positive image than before. These policy decisions completely disregarded public health considerations.

Prevention Effects

The ministry of Welfare is primarily responsible for preventing alcohol consumption. Among its many other responsibilities, substance abuse has been relegated to a low priority. Whatever efforts are made are targeted more toward illegal drugs and less toward alcohol. In practical terms, alcohol prevention programmes amount to media advertisements and the financing of some non governmental organization to operate counseling and rehabilitation centers. Most of these centers are located in urban areas, leaving large areas of rural India unserved by my organized activity in this field.

TREATMENT FACILITIES

It has been estimated that there are fewer than 2000 beds for drug and alcohol related problems with the support or ministry of health of Indian Government, which is extremely small minuscule number for the several million individuals who need such assistance in India.

Private medical facilities have some what filled this gap, but they are so expensive that only a few wealthy patients can use them. These services are also completely concentrated in the large cities.

The detection and treatment of alcohol related problems in health care facilities is extremely poor. Awareness of alcohol problems and skills in the recognition and treatment of them at a primary level is highly deficient. Some training programmes to improve the skills of planning care personnel in this field have begun, but in the absence it of follow-up support or monitoring they have not had much impact on the services rendered.

Community and Non Governmental organization activities

Alcohol was not on the Community action agenda until about 1 0years ago. But in the past number of movements have sprung up in opposition to excessive drinking. Perhaps the best known of these is the anti alcohol action by rural women in Andhra Pradesh (Saxena 1994 a) Many women groups joined the movement and took action against the alcohol sales and finally the Andhra Pradesh Government was persuaded to declare prohibition through out the state. Inspired by this success, many other groups mostly led by women – have resorted to direct action, but so far they have not had much success. Even in Andhra Pradesh, the State Government has now had removed the prohibition due to the economic losses from no alcohol sales.

Some non-governmental organisation have entered the alcohol field and have been supported with government finances. They have provided counselling and rehabilitative services, but their impact has yet to be felt nationally. Each state government has temperance board but these are only in name sake.

Alcohol has been used in India for a very long time, but the amounts consumed and problems associated have increased in recent years. Distilled alcohol bergs are the ones drunk most frequently, although beer has become more popular among the young. Besides licensed beverages, illicit alcohol is widely available and may amount to half against the quantity of legal alcoholic beverages. The recent economic Liberalisation policy has allowed multinational liquor brands entry to the Indian market, which may further increase the quantities of alcohol consumed.

Although most of the population is abstinent, available evidence points to higher levels of drinking with associated health and social problems among those who do drink. These have already created serious public health problems and they also impede the development of poorer regions of the country especially urban slums and rural areas. Policy responses to date from the federal and state governments have been inadequate and inconsistent, resulting in the unopposed promotion of alcohol in most of the country. Prevention programmes and treatment facilities are wholly insufficient to meet India's needs. It can be anticipated that alcohol use and related problems will grow in every Indian state with the manner of unimaginable manner. Unless planned policy changes are designed and vigorously implemented these problems are likely to produce an excessive burden on every state and country's resources.

Invitees for a consultation to prepare a concept paper to control alcohol related problems for the State Level Consumption

1.	Dr.C.M.Francis	14.	Justice Balakrishna (retired)
2.	Ms.Devaki Jain	15.	Dr.Marie Mascharenas
3.	Ms. Shanthi Ranganthan	16.	Dr.Anitha Reddy
4.	Dr.Mohan issac	17.	Ms.Mohini Giri – Women's Commission
5.	Dr.Thelma Narayan	18.	Delegate from Psychiatry Dept. of St.John's
6.	Dr.Joga Rao	19.	Ms.Jacida Kumar – Sakthi
7.	Prof. Babu Mathew	20.	Ms.Susheelamma – Samankali Sevasashrama
8.	Dr.Sudharshan	21.	Ms. Vimala – Corporation Bank
9.	Ms.Donna Fernandes (Vimochana)	22.	Mr.Ramesh Ramanathan Janagraha
10.	Mr.Vijaya kumar (World Vision)	23.	Dr.Pruthvish
11.	Dr.Vivek Benegal	24.	Dr.Lakshman – Mind
12.	Dr. Prathima Murthy	25.	Dr. Ahkwaja
13.	Ms.Ruth Manorama		

List of Invitees for State level consultation on Alcoholism

1.	Nimhans, Director	5	Dr.Vivek Benegal
2.	Dr.Gangadharan	6	Dr..Kuru Raj
3	Dr.Mohan Isaac	7	Dr.Sekar Sheshadri
4	Dr.Pratima Murthy		

Government :

1.	Health secretary and Commissioner	9	Justice Saldhana and Legal Experts
2.	Finance secretary and Commissioner	10	Mr. Joga Rao Law School
3	Excise duty Commissioner	11	Mr. Babu Mathew – Law School
4	Health and excise Ministers	12	Mr. Rajagopal, Chairman, State Police housing Corp
5	Nation Centre for Drug Abuse and prevention	13	Justice Balakrishnan
6	Temberance	14	Vice Chancellor of Medical University Dr.Chandrashekar
7	Drug Abuse Division, WHO, New Delhi	15	Dr. T.K.Srinivsan
8	State Police - DGP	16	Chief Justice of Karnataka High Court

Experts and Eminent people

1.	Mr.L.C.Jain	10	Dr.Marie Mascranus
2	Dr Sudarshan	11	Ms.Padmasini Asuri
3	Dr.Lakshman	12	Ms.Sudha Murthy
4	Women's of India (Organisation)	13	Ms. Kalpana Lehar
5	Ms.Donna Fernandis	14	Dr.Latha Jaganathan
6	Ms Ruth Manorama	15	Mr Ali Khwaja
7	Ms.Mohini Giri	16	Mr.Hassan Mansur
8	Dr.Saraswathi Ganapathi	17	Ms.Shanthi Ranganthan
9	Ms.Sakuntala Narashima		

Religious People

1.	Arch Bishop of Bangalore
2.	Fr. Kallam
3	Fr. Aral Joseph – CBCI, Secretary
4	Fr.Claud

Community Medicine Departments and Psychiatry department of All Medical colleges

1.	St. John' Medical College
2.	M.S. Ramaiah Medical College
3	Bangalore Medical College
4	Ambedkar

Trade Unions and Industries

1.	Trade Unions	13.	B P L
2.	Major Industries	14.	M I C O
3.	City Colleges	15.	Philips
4.	KSRTC	16.	Volvo
5.	PARMADA	17.	L & T
6.	TVS	18.	Pepsi
7.	Kirloskar	19.	Parle
8.	Infosys	20	Himalaya
9.	Wipro	21.	Widia
10.	IICL	22	Jindal
11.	H P	23.	Microland
12.	Britania	24	Mind tree

NGO's

1.	Freedom Foundation	32.	CREaT – Muralidhara
2.	TREDA	33.	Respect for Life
3.	World Vision	34.	Sanjivini Trust
4.	Navajeevan	35.	Maithiri Sarvaseva Samithi
5.	Deeds	36.	Outreach
6.	Kanthi Kiranam	37.	Sakthi
7.	REDS	38.	AVAS
8.	APSA	39.	Paraspara
9.	APD	40.	CIVIC – Concern for Working Children
10.	BOSCO	41.	YMCA
11.	KKNSS	42.	Asha Deep
12.	Women' Voice	43.	St.Martha Hospital
13.	Vimochana	44.	Madhyam
14.	BMST and TTK Chennai	45.	ISI
15.	Mamta	46.	ICDSS
16.	Janodaya	47.	BMSSSS
17.	TRED	48.	Vokes
18.	Rotary Club	49.	CIVIC
19.	Lions Club	50.	Action Aid India
20.	CHAI	51.	Joint Womens programe
21.	CMAI	52.	NAPM
22.	VHAI	53.	Basic Needs
23.	PUCL	54.	Parinati
24.	MAYA	55.	Sr.Aquinas – CRHP
25.	Preethio Mahiladava – Sr.Celia	56.	Mahila Samakhya
26.	BIRDS	57.	AIDWA
27.	Sandeep Seva Nilaya	58.	NESA
28.	Drug Action Forum	59.	FEVORD K
29.	BGOS	60.	Belaku Trust
30.	FRLHT	61.	Alcoholics Anonymous
31.	Ms.Padmasini Asuri	62.	Al-Anon

MH-2

How to Protect Your Children from Child Abuse and Drug Abuse:

A Parent's Guide

NOTE TO PARENTS:
Tear out this 28-page guide and keep for future reference.

Boy Scouts of America

Introduction

For over three quarters of a century, the Boy Scouts of America has worked to develop the character, citizenship, and personal fitness of America's youth. We realize that the future of our society is vested in each successive generation and the values inherited.

Today, as we look toward the 21st century, society is challenged by those who would prey upon America's youth—either by altering their minds with illegal substances or through physically or sexually assaulting their bodies. These scourges—drug abuse and child abuse—must be eliminated.

As a major youth-serving organization, the Boy Scouts of America has a unique opportunity to help protect the youth of our nation. This booklet will help parents teach their children self-protection strategies. In it are basic protection strategies and activities that parents may do with their children. By doing these exercises, parents will also be developing the kind of open communication that will enable their children to feel comfortable discussing sensitive problems or telling them about experiences involving inappropriate adult behavior. Some of the exercises may count toward completion of advancement requirements in Cub Scouting and Boy Scouting.

How to Protect Your Children from Child Abuse and Drug Abuse: A Parent's Guide is designed to provide parents and their children with basic information that will increase awareness of the magnitude of these problems and their manifestations. Through this effort, the youth that are given knowledge and a sense of personal power will be able to assist in their own self-protection. We as adults owe children all the safety we can possibly provide.

Section 1

Youth Protection: Child Abuse

The Boy Scouts of America is deeply concerned about the general welfare of our nation's children. There are many challenges that confront today's youth and child abuse is one of these. Child abuse is a fact in our society and a matter of great concern for all parents. Fortunately, child abuse is preventable, but parental action is important to protect children. The first responsibility that parents have is to be sure their children are safe from abuse in the home. Unfortunately, studies show that more children are abused in the home than anywhere else, often because of inappropriate or excessive punishment.

Raising children in today's complex society is a difficult, demanding, stress-filled responsibility. The National Committee for the Prevention of Child Abuse gives the following suggestions to avoid unintentional physical or emotional abuse:

The next time everyday pressures build up to the point where you feel like lashing out—**STOP!** And try any of these simple alternatives. You'll feel better . . . and so will your child.

- Take a deep breath. And another. Then remember *you* are the adult.
- Close your eyes and imagine you're hearing what your child is about to hear.
- Press your lips together and count to ten. Or better yet, to twenty.
- Put your child in a time-out chair. (Remember the rule: One time-out minute for each year of age.)
- Put your self in a time-out chair. Think about why you are angry: Is it your child, or is your child simply a convenient target for your anger.
- Phone a friend.

- If someone can watch the children, go outside and take a walk.
- Splash cold water on your face.
- Hug a pillow.
- Turn on some music. Maybe even sing along.
- Pick up a pencil and write down as many helpful words as you can think of. Save the list.

Few parents intentionally abuse their children. When parents take time out to get ahold of themselves before they get ahold of their children, everybody wins.

Parents also need to discuss the possibility of abuse outside the home with their children and provide reassurance that any time a child feels threatened, the parents will be there to discuss the problem and support the child.

One form of abuse that parents find especially difficult to discuss with their children is sexual abuse. By overcoming the discomfort that they experience when children bring up sensitive subjects such as sexual abuse, parents may greatly reduce their children's chances of being abused.

The Three R's of Youth Protection

The three R's of youth protection are the key to an effective youth protection strategy:

Recognize. The child needs to be able to recognize the situations in which he may be at risk of abuse. Traditionally, children have been told of the risks associated with strangers. As we have come to learn, in most cases, child abuse is committed by a person known to the child, often one in a position of authority over him. Therefore, if we only teach them to be wary of strangers, we are not protecting our children as completely as we must. The exercises in this booklet will help your child learn to identify situations requiring caution.

Resist. The child needs to be able to assert his rights to resist the abuser. Interviews with child molesters document that when a child resists advances made by a molester, the molester will usually abandon further attempts with that child. Only a very small percentage of child molestation involves the use of physical force. Children need to be trained to "run, scream, or make a scene" when inappropriately approached by *anyone*—friend, relative, or stranger.

Report. The child needs to be able to tell an adult when he has encountered abuse, with the expectation that the adult will take action to prevent further abuse. Children need to be taught to tell their parents, teachers, or other adults whenever they encounter questionable situations or attempted abuse. Since adults do not always listen when children talk to them, the children need to be told to keep on telling until someone listens.

Sometimes, a child may not be able to talk about what has happened, but will communicate in other ways. For example, he may go out of his way to avoid being alone with a particular person. This is a kind of communication to which parents need to be sensitive, as it may be an indicator of abuse.

When a Child Discloses Abuse

If your child becomes a victim of abuse, your initial reaction can be very important in helping him through the ordeal. The following guidelines may help you.

- **DON'T** panic or overreact to the information disclosed by the child.
- **DON'T** criticize the child or claim that the child misunderstood what happened.
- **DO** respect the child's privacy and take the child to a place where you and he can talk without outside interruption and distractions.
- **DO** reassure your child that he is not to blame for what happened. Tell him that you appreciate his telling you about it and and that you will help make sure that it will not happen again.
- **DO** encourage your child to tell the proper authorities what happened, but try to avoid repeated interviews. This can be very stressful for the child.
- **DO** consult your pediatrician or other child abuse authority on the need for counseling to help your child.

Finally, if abuse happens to your child, do not blame yourself. Individuals who victimize children are not readily identifiable; they come from all walks of life and all socioeconomic levels. Often they present a nice image—they go to church and are active in the community. The molester is skilled at manipulating children, often by giving excessive attention, gifts, and money. Most abuse occurs in situations in which the child knows and trusts the adult.

If you would like to learn more about child abuse and protecting your child, the Boy Scouts of America provides a ninety-minute training program, Youth Protection Guidelines: Training for Volunteer Leaders and Parents. Contact your local council for scheduling and availability.

Teaching Your Child to Be Assertive

It is important that your child understands the right to react assertively when faced with a situation he or she perceives as dangerous. When teaching your child self-protection skills, make it clear that although some basic strategies involved seem to contradict the sort of behavior you might normally expect of your child, these strategies apply to a situation that is *not* normal. When feeling threatened, your child must feel free to exercise the right to:

- trust his or her instincts and feelings
- expect privacy
- say no to unwanted touching or affection
- say no to adult demands and requests
- withhold information that could jeopardize his or her safety
- refuse gifts
- be rude or unhelpful if the situation warrants
- run, scream, and make a scene
- physically fight off unwanted advances
- ask others for help

It's important to remember these are protective strategies designed to give youth the power to help protect themselves. The following exercises will help to clarify when it is appropriate to apply these strategies.

Exercise 1: What if . . .

In this exercise the parent sets up situations that the child should recognize as potentially dangerous. Once the parent describes a situation, the child tells what he would do if ever confronted in such a way. You can extend some situations by replacing the individual in the scenario with someone that your child knows, such as a neighbor, relative, or someone who has a position of authority. Your child needs to understand that inappropriate behavior is wrong, irrespective of who does it. Suggested action is listed with each situation. (Credit may be given for Wolf Achievement 12: Making Choices.)

Situations for Younger Children

1. You are home alone and the telephone rings. A voice on the other end asks if your parents are home. What do you do?
   A. Tell the caller your parents are busy and cannot come to the phone.
   B. Take a message and the phone number of the caller.
   C. Ask if the message needs an immediate response, and telephone your parent if it does.
   D. Do not tell the caller you are home alone.
2. An older boy is hanging around your school and tries to give pills to younger students. What do you do?
   A. Tell your teacher.
   B. Tell your parents even if you told the teacher.
   C. Stay away from the boy with the pills.
3. You are home alone (or with your brother or sister) and a man knocks on the door and says he wants to read the electric meter. He is not wearing a uniform. What do you do? (A good alternative situation is to have the man wearing a uniform. Appropriate responses would probably not be different.)
   A. Always keep the doors locked.
   B. Do not open the door to anyone without permission from a parent.

C. Tell the man to come back later when your parent can come to the door. Do not let the person know your parents are away.

D. Use the telephone to call a neighbor and ask for assistance.

4. Someone comes up to you and says that your parent is sick and you are to go with him. What do you do?

A. If at school, go to the principal or your teacher for assistance and verification.

B. If at home, or somewhere else, call the emergency number, parent's employer, neighbor, close relative—for assistance and verification.

C. Do not go anywhere without proof from someone in authority who you have been told to trust.

5. You are in a public restroom and someone tries to touch you. What do you do?

A. Yell "STOP THAT" as loudly as you can.

B. Run out of the room as quickly as possible.

C. Tell your parents, a police officer or security guard, or other adult (such as your teacher) what happened.

6. You are walking to school in the rain. A car stops and its driver asks if you want a ride. What do you do?

A. Stay away from the car—you do not need to go close to the car to answer.

B. Unless you have your parent's permission to ride with the person, say NO.

C. Tell your teacher when you get to school and tell your parents when you get home.

7. You are playing on the playground and an adult comes up to you and asks you to help find his lost puppy. What do you do?

A. If you do not know the person stay away from him and go directly home.

B. Even if you know the person, do not help. Adults should ask other adults for help. Before you help, you must get your parent's permission.

C. Tell your parents what happened.

8. You are walking down the street and a man comes up to you and wants to take your picture. He asks you to come to his house. What do you do?

A. Avoid the man and tell him in a loud voice, "NO! I don't want my picture taken!"

B. Never go in to anyone else's house without your parent's permission.

C. Tell your parents about the man.

9. Your friend's older brother tells you that he wants to play with you and he will be the doctor and you are the patient. He tells you to take off your clothes so that he can examine you. What do you do?

A. Keep your clothes on.

B. If he persists, yell at him and get away.

C. Tell your parents.

Situations for Older Children

1. You get on a bus by yourself and a person sits down next to you and puts his hand on your thigh.

A. State in a clear, firm voice loud enough to hear, "No. Take your hand off."

B. Move to the front of the bus near the driver.

C. Tell the driver and tell your parents when you get home.

2. While collecting on your paper route, a woman customer offers you a beer, puts her arm around you, and says what a fine body you have.

A. Tell her, "I don't like that, take your arm off me."

B. Tell your parents when you get home.

3. A friend of your cousin offers you a ride home, but instead of taking you home, he drives down a dead-end street, parks, and starts rubbing his hand on your leg.

A. Tell him NO in a firm loud voice.

B. Get out of the car and go to the nearest telephone—if too far to walk home—and call your parents or the local police.

C. Tell your parents what happened.

4. You are baby-sitting for a family who got your name from the bulletin board at the grocery store. They return late at night, and apparently they have been drinking. As you are being driven home, your employer makes suggestions that make you feel uncomfortable.

A. It's dangerous to advertise on the bulletin boards and newspapers. It is much safer to babysit for people you know.

B. Do not babysit for these people again.

C. Tell your parents what happened.

Exercise 2: My Safety Notebook

This exercise will help your child be prepared to avoid situations that could lead to abuse or molestation. The safety notebook can be a loose-leaf notebook or pages fastened with staples for which he has made an original cover. (Credit may be given for Bear Elective 9: Art, and Webelos Artist activity badge.)

The safety notebook provides a place your child can list emergency telephone numbers, including parents' work numbers and a neighbor or friend's number to be contacted when parents are unavailable. (Credit may be given for Wolf Achievement 4: Know Your Home and Community.) In addition, your child can list the safety rules that you have discussed with him. Encourage him to decorate each page with pictures and drawings that illustrate some of the rules.

He also may want to list other kinds of safety guidelines such as rules for bicycle safety. (Credit may be given for Wolf Achievement 9: Be Safe at Home and on the Street, Bear Achievement 14: Ride Right, and Webelos Readyman activity badge.)

"My Safety Notebook" is intended to be a fun activity for getting across some serious concerns. It is a personalized reference source that can reassure your child that he knows how to respond when confronted by a potentially dangerous situation.

Exercise 3: Child Abuse and Being a Good Scout

When a boy joins the Scouting program, he assumes an obligation to be faithful to the principles of Scouting as embodied in the Cub Scout Promise, Law of the Pack, Cub Scout motto, Scout Oath, Scout Law, Scout motto, and Scout slogan.

The principles of Scouting do not require that a Scout place himself in potentially perilous situations—quite the contrary, we want Scouts to "be prepared" and "do their best" to avoid these situations.

We hope that you will discuss these with your Scout and be sure that he understands the limitations to the requirements in consideration of the rules of safety.

Cub Scouts

The Cub Scout Promise includes the phrase, "to help other people." This means that a Cub Scout should be willing to do things for others that would please them, but *only* when his parents have given permission, and know where he is and who he is with.

The Law of the Pack includes the statement, "The Cub Scout follows Akela." Akela is a good leader and should never ask the Cub Scout to do something that the Cub Scout feels bad about. If Akela, who may be a teacher, coach, or other youth leader, ever asks the Cub Scout to do something the Cub Scout thinks is bad, the Scout has the right to say NO! and will tell his parents.

Boy Scouts

The Scout Oath includes the phrase, "to help other people at all times." The Scout Law says that a Scout is helpful, and the Scout motto is "Do a Good Turn daily." There are many people who need help and a Boy Scout should be willing to lend a hand when needed. Sometimes, people who really do not need it will ask for help to create an opportunity for abuse. Boy Scouts should be very familiar with the rules of safety so that they can recognize situations to be wary of. For example:

- It is one thing to stand on the sidewalk away from the car to give directions and something else to get in the car and go with the

person to show them where to go. A Scout should never get into a car without his parent's permission.

- It may be okay for a Scout to help carry groceries to a person's house, but he should never go into the house unless he has permission from his parents.

The Scout Law also states that a Scout is obedient—but a Scout does not have to mind an adult when that person tells him to do something that the Scout feels is wrong or that makes the Scout feel uncomfortable. In these situations, the Scout should talk with his parents about his concerns.

Exercise 4: Plays and Skits

Children might enjoy creating a script for a play or skit that will dramatize their understanding of the safety rules. The skit may then be presented to other children as a service project. (Credit may be given for Wolf Elective 2: Be an Actor, Webelos Showman activity badge, and service projects for Boy Scout Star and Life ranks.) As a parent, you can guide the creation of the script so that the situations are reality based and show successful avoidance of abuse. It is important that children feel that they *can* protect themselves.

Exercise 5: Family Meeting

The one most important step that parents can take to protect their children from abuse is to establish an atmosphere of open communication in the home. Children must feel comfortable bringing sensitive problems to their parents or relating experiences in which someone approached them in an inappropriate manner or in a way that made them feel uncomfortable. Studies have documented that over half the abuse of children is never reported because the victims are too afraid or too confused to report their experiences.

It is important that your children be allowed to talk freely about their likes and dislikes, their friends, and their true feelings. One way to create open communication is through family meetings at which safety issues can be addressed by the entire family. (Credit may be given for Webelos Family Member activity badge.) The "what if"

exercises could be done as part of a family meeting, as could the development of safety rules for the safety notebook.

Basic Rules of Safety for Children

As we address the basic rules for child safety, it is important to stress that traditional cautions about strangers are not sufficient to protect our children. Because the child abuser is usually known to the child, a more appropriate protection strategy is based upon teaching children to recognize situations or actions to be wary of. Children should be taught:

- If you are in a public place and get separated from your parent (or authorized guardian) do not wander around looking for him or her. Quickly go to a police officer, checkout counter, the security office, or the lost and found department and tell them that you have been separated from your parent and need help.
- You should not get into a car or go anywhere with any person unless you have your parent's permission.
- If someone follows you on foot or in a car, stay away from him or her. You do not need to go near the car to talk to the people inside.
- Adults and older youths who are not in your family and who need help (such as finding and address or locating a lost pet) should not ask children for help; they should ask other adults.
- You should use the "buddy system" and never go anywhere alone.
- Always ask your parent's permission to go somewhere, especially into someone else's home.
- Never hitchhike.
- Never ride with anyone unless you have your parent's permission.
- No one should ask you to keep a special secret. If this happens, tell your parents or teacher.
- If someone wants to take your picture, tell your parents or teacher.
- No one should touch you in the parts of your body that are covered when you wear a bathing suit (unless it is your doctor while

treating you or during a physical examination), nor should you touch anyone else in those areas. Your body is special and private.

- You have the right to say "NO!" to someone who tries to take you somewhere, touches you, or makes you feel uncomfortable in any way.

These are some simple safety rules that can be approached in the same non-frightening manner in which you tell your child not to play with fire. They emphasize situations common to many child molestation cases.

Section 2

Youth Protection: Drug Abuse

Our country is in the grip of a drug abuse crisis. We are seeing kids—only 9, 10, or 11 years old—playing a deadly game of Russian roulette with their hearts, their livers, and in particular, with that most marvelous and delicate organ, their brains. Our brains are better by far than any computer man can invent. Let's say you have a computer with 64K memory, and you blow out half the circuits. That computer may still be able to perform some simple functions, but it's never going to be able to do the complex, sophisticated tasks it was designed to do. That's true of your brain, too.

What are Drugs?

A drug is a chemical substance that can be absorbed in the body. All drugs, legal and illegal, can kill if improperly used.

Illegal drugs are sold unlawfully on the street. Legal drugs are prescribed by a doctor.

Cigarettes are drugs! Beer is a drug! Cocaine and crack are drugs! *All* drugs can be addictive. Once a person tries them, he or she builds an appetite for them. They can be dangerous and deadly, and burn out the brain.

Drugs can produce a pleasurable effect on the mind and fool a person into thinking he or she feels better, or acts better, or thinks better, or plays games better. At first, that may seem to be true—but each time the person takes a drug, he or she will fail to perform as well as before.

No. 1 Killer: *Tobacco.* Tobacco is the number one killer drug and is directly related to the death of almost four hundred thousand people each year! Every day more than three thousand teenagers start

smoking. After age 20, every pack of cigarettes can shorten a person's life by 137 minutes. Nicotine in cigarettes clogs blood vessels, shortens breath, and more. Chewing tobacco can give a person mouth cancer.

No. 2 Killer: *Alcohol.* Alcohol is in wine, beer, cocktails, and wine coolers. Beware! One can of beer contains as much alcohol as 1 ounce of liquor. One can of beer can affect a person's reasoning, judgment, breathing, and body coordination, and can cause dizziness and a fuzzy head. After five beers a person is legally intoxicated, and it takes as much as three and a half days to recover reflexes and normal brain function.

No. 3 Killer: *The mixture of marijuana, beer, and driving.* As kids get older, some are tempted to try marijuana and beer. Beer or other alcohol and marijuana taken together can cause a drug overdose. Each doubles the effect of the other. For example: one marijuana cigarette (joint) plus one beer is like drinking three beers or smoking three and a half joints.

Other Killer Drugs: *Cocaine*: Once a person becomes hooked on cocaine, he or she can't control the need for more. Cocaine reduces performance. For some, cocaine seems to improve performance the first time it's used. But performance drops off and the user (abuser) doesn't know it or believe it because cocaine fools the brain into thinking one is doing great. Wrong! Real performance gets worse and worse every time it's used.

Steroids: It is a popular myth that using steroids will improve performance. Steroids have many bad effects for young people. They increase weight and strength, but can cause wide mood swings and aggressive behavior, acne and pimples, bone damage, and a decrease in sex drive.

Marijuana: This is most commonly used by teenagers who start experimenting with drugs. It contains a mind altering substance that stays in the brain one month after smoking one marijuana cigarette. It often leads to other, more serious, drug usage.

Note: The first use of alcohol and illegal drugs can lead to serious trouble, even death. Diet pills are drugs too, and very dangerous.

Join the Crusade Against Drugs

Drug and alcohol abuse is the most serious threat to the well-being of our children and to their future. Alcohol is America's number one drug problem among youth. Using alcohol, a "gateway" drug, usually precedes using other drugs. It kills approximately ten thousand young people, 16 to 24, in alcohol-related accidents of all kinds, including drowning, suicides, violent injuries, homicides, and injuries from fire. Tens of thousands of teenagers are frequent [illegible]nkers. Other thousands smoke, snort, and inject illegal drugs with frightening regularity.

Now there is evidence that the drug menace is dipping even lower on the age scale. Growing numbers of preteen children are experimenting with alcohol and drugs.

The Boy Scouts of America has joined the national crusade to combat drug and alcohol abuse.

How Bad Is the Problem?

Our teenagers use far more drugs than those of any other developed nation. High school drop-out rates are rising as much as 54 percent in some city schools. Much of this is drug related. Drug abuse is slightly lower in rural areas, but not much; it is a national scourge.

We all know there's a problem, but how big is the problem, really? Do we have any statistics, any figures? According to recent surveys by the National Institute on Drug Abuse (NIDA):

- About 61 percent of high school seniors have tried an illegal drug. About 40 percent have tried an illegal substance other than marijuana.
- By the senior year of high school, 17 percent of our nation's youth have tried cocaine. Six percent use cocaine at least once a month.
- Twenty-six percent of seniors smoke marijuana.
- One in 20 seniors drinks alcohol, and 37 percent have had five or more drinks in a row at least once in the prior two weeks.
- Two out of five high-school senior boys admit having been drunk in the past year.

- Thirty percent of seniors have smoked cigarettes, and 20 percent are daily smokers.
- By the twelfth grade only about 10 percent of youth have never used an illegal substance.

Although there is some good news indicating that older teenagers—high school and college students—are now using fewer drugs than they did in the early 1970s, there is also some *really bad* news. Kids are experimenting with drugs and alcohol at earlier ages. Today one in six 13-year-olds has tried marijuana. Many admit having used alcohol and pot before they were 12—too young to know that they have joined a deadly game.

No question there's a problem—a problem so vast we may feel helpless. But there *are* things we can do, things that can affect those closest to us—our families, our Scouting friends, our neighbors and neighborhoods. Things that, as prevention, could make more difference than we would ever know.

Why Children Use Drugs

Wanting to fit in with other kids has always been the norm among youth. Remember your childhood? Was it not the same? Well, it is exactly the same with today's children.

Most youth want to do things that are "in." If drugs and alcohol are the "in" things to do, they will want to try them. A recent survey showed that:

- For all children who smoke marijuana, the most important reason is "to fit in with others."
- For fourth- and fifth-graders, the second most important reason is "to feel older."
- For those in grades six through twelve, it's "to have a good time."

Fourth-graders are greatly influenced by television shows and movies that glamorize alcohol and drugs—even though only the "bad guys" use them. From fifth grade on, peer pressure is the primary influence on children who try alcohol and drugs.

These facts tell us that if we are going to stop the deadly game, we should start with Cub Scout-age children.

What Scouting Units Can Do

One of the primary goals of the Boy Scouts of America is physical, mental, and moral fitness. Many activities in Cub Scouting, Boy Scouting, Varsity Scouting, and Exploring bear directly on that goal, and so they offer innumerable opportunities for educating our members about alcohol and drug abuse. Here are some examples.

Cub Scouting

- Den leaders can use advancement requirements to lead into a discussion of the dangers of alcohol and drugs and how boys can resist them. For example, boys working on Wolf rank are asked in Achievement 12 (Making Choices) to tell what to do if they are offered pills in the schoolyard. Boys working on Bear Achievement 7 (Law Enforcement Is a Big Job) may learn why it is so important for the police to control drug trafficking. The den leader could arrange a den visit to a police station to talk with an officer about it. For Webelos Scouts, the Fitness activity badge requirements encourage boys to resist peer pressure to try alcohol and drugs.

- Den leaders and Cubmasters may use an occasional leader's "minute" to talk about the dangers of drug abuse. Avoid preachiness but make the point that the best "highs" come from the fun of Scouting, other youth groups, and sports—not from alcohol and drugs.

In Boy Scouting and Varsity Scouting

- Adult leaders and older Scouts can use the requirements for the Personal Fitness merit badge to lead Scouts to understand the dangers of drug abuse. A high school coach or Personal Fitness merit badge counselor might moderate a troop discussion about drugs and alcohol.

- Candidates for Star, Life, and Eagle rank could be encouraged to give service to parents' groups and community centers that are fighting drug abuse among youth.

- The Scoutmaster or Coach might focus on drug abuse for an occasional Scoutmaster's minute or Coach's corner.

In Exploring

Explorer groups can go into school classrooms in the lower grades to make presentations on drug abuse. They are particularly effective for Cub Scout- and Boy Scout-age groups. The younger boys look up to them.

If there is such an Explorer post in your area, it could be invited to present the program for your pack, troop, team, or post. Check with your local council service center.

Your unit may also get help from local parent and youth groups that are fighting drug abuse.

What Parents Can Do About Drug Abuse

As a caring parent—the greatest influence on children—you also can help your children resist the lure of alcohol and drugs by doing the following:

1. Squelch the notion that drug abuse "can only happen to other people's kids." The truth is that it can happen to anybody's kids.
2. Teach your children that using drugs is wrong, harmful to their growing bodies, and illegal. You can set the example by not using drugs yourself.
3. Supervise their activities outside the home as much as possible. Know who their friends are and what they're doing.
4. Talk with your children about their interests and problems. Listen to them. If they can open up to you, they are much less likely to turn to alcohol and drugs for relief from problems.
5. Learn the signs of drug use and respond promptly if you observe any in your children. The earlier a drug problem is spotted and faced, the easier it is to overcome.
6. Ask your local council service center (see Boy Scouts of America in your telephone book) for a copy of the booklet *Drugs: A Deadly Game.* It contains practical ideas for family- and Scouting-related projects and discussions. Sample these, for instance:

TRUE OR FALSE? Heroin is addictive, but cocaine is not.

FALSE! Cocaine is addictive to many of the people who try it. When people are addicted to heroin, alcohol, or amphetamines, they go a little crazy when they can't get it. It's the same with cocaine addicts. They'll do just about anything to get drugs—things they wouldn't dream of doing if they weren't addicted—like lying and stealing.

TRUE OR FALSE? The effects of marijuana wear off in a few hours.

FALSE! The feeling of being high may last for only a few hours. But we now know that a person's ability to do complicated tasks can be affected for as long as twenty-four hours. Even if someone is smoking only after school, he or she may eventually find it harder to concentrate during regular school hours.

7. Ask your local council service center if you may borrow the video *Drugs: A Deadly Game.* Show this to your family and then discuss it.
8. Be alert for press, television, and radio features on drugs. Watch, read, and listen together, then discuss what you learn. Consider taping television and radio programs for further use.
9. Discuss with your children how the use of drugs, including alcohol and tobacco, could seriously handicap their physical and mental capacities. For example, in Scouting, attempts to pass advancement requirements such as physical fitness, hiking, swimming, Personal Fitness merit badge, etc., would be greatly hindered.
10. Is there a drug abuse hotline in your community? Ask a representative to explain how the hotline deals with callers who need help.

The Signs of Drug Abuse

A child under the influence of alcohol or other drugs may have various symptoms, depending on the substance. But for all drugs, you are likely to observe slurred or incoherent speech, memory lapses, and indifference to hygiene and grooming.

Most people recognize alcohol abuse because of the pronounced odor. For other common drugs, look for the following signs:

- **Marijuana.** Bloodshot eyes, dry mouth, increased appetite. Comprehension and short-term memory may be impaired. Coordination may be reduced.
- **Cocaine and Crack.** Dilated pupils and stuffed or runny nose. Respiratory and heart rates speed up. Crack users may suffer insomnia, loss of appetite, paranoia, and seizures.
- **Inhalants** (laughing gas, aerosol sprays, solvents, others). Inhaling them causes nausea, sneezing, coughing, nosebleeds, and loss of appetite and coordination. Some inhalants also cause headaches and involuntary passing of urine and feces.
- **LSD and PCP** (phencyclidine). Dilated pupils, hallucinations, higher heart rate and blood pressure, loss of appetite, sleeplessness. PCP users have incoherent speech, dulled senses, and poor coordination.
- **Heroin and Other Narcotics.** Feeling of euphoria often followed by drowsiness, nausea, and vomiting. Users may have constricted pupils, watery eyes, and itching.

If You Suspect Drug Abuse

If you have reason to believe your child is using drugs or alcohol, face the problem. Don't ignore the signs. Your child needs help.

Experts recommend that a parent who observes signs of drug abuse should:

- Discuss the problem with the child in a calm, objective manner. Do not confront the child while he or she is under the influence of drugs.

- Impose disciplinary rules that remove the child from the circumstances where drug abuse might occur (perhaps a curfew, closer supervision, or forbidding the child from seeing certain friends).
- Seek advice and assistance from a drug treatment professional and from a parent group.

Family Discussions

It's important to keep the lines of communication open within the family. An environment that is supportive of adolescents is crucial. Things that have nothing to do with drugs—like someone to talk to—may be the real deterrent to drug abuse.

Discussing the different myths about drug use is a good way to get children to open up. Listed below are several myths that parents can discuss with their children:

Myth No. 1: You won't become addicted to cocaine with casual use.

Fact: The two million cocaine addicts will tell you differently. The up-and-down cycle of the cocaine user who always needs more to get a kick is often started with casual use and often continued without the user knowing he or she is becoming addicted.

Myth No. 2: One time can't hurt you.

Fact: More potent, more available, and more lethal than ever, cocaine, heroin, and a rapidly increasing list of synthetic drugs can threaten the life of even a first-time user. Cocaine, once thought to be less dangerous than other drugs, accounted for more than 350 deaths in 1986. Today's marijuana has three times the amount of THC (the main mind-altering ingredient in marijuana) than marijuana that was available in the 1960s and early 1970s.

Myth No. 3: The most dangerous drugs have been outlawed.

Fact: New synthetic "designer" drugs are being marketed amazingly fast so that, as one drug expert noted in *U.S. News and World Report* (July 28, 1986), "These drugs haven't been tested. No one is even sure about the toxic effects. But people are still lining up to buy them. . . . The public is taking the role of guinea pigs."

Additional family discussions can focus on the following:

1. Discuss what someone would look like if he or she were using cocaine, marijuana, or alcohol, or smoking cigarettes.
2. Discuss different ways of saying "no" diplomatically but firmly, without feeling embarrassed.
3. Discuss peer pressure and how peers affect decision making. Ask your children to think of some examples in which friends influenced their decision about something.

Section 3

How to Communicate with Kids

Communicating with kids—yours or someone else's—isn't all that easy, particularly when the subject is something like drugs or child abuse. It's not easy, but neither is it impossible, especially if you keep these tips in mind:

- Establish rapport. Rapport comes from a record of friendly, honest, face-to-face adult/kid relations. Welcome their suggestions. Laugh at their jokes. Downplay the lectures. Stay flexible—but stay firm.
- Don't wait till there's a problem. Play and work and talk together as part of the normal, day-to-day routine. Then, when a problem hits, you can communicate.
- Whenever possible, join the group your kid joins—or at least work closely with it. Sign up as a leader in your boy's Cub Scout pack or Boy Scout troop, for example. This not only gives you chances to have fun together, but also puts you in a position to help choose the other leaders, stress the values important to you, and influence the program.
- Use peer pressure—the influence of kids on other kids—to help get your message across. A street gang, school group, ball team, Cub Scout pack, Boy Scout troop, or Explorer post can turn a youth on—or off. Guide the majority—or the influential minority—toward the right attitudes and actions. And they, perhaps without conscious design, will begin working on the rest.

Section 4

Scouting's Weapons for Youth Protection

"It is time," writes Chief Scout Executive Ben Love, "to take an active role in the betterment of our world. We must wholeheartedly accept our responsibility to protect the weak, the needy, and the destitute."

Has Scouting a weapon for such an active role? Indeed, it has two weapons, in fact.

The first is a weapon we call service. In Scouting it's also known as goodwill, the Good Turn, and helping others.

The second weapon packs a different kind of punch, but its power can be impressive. We're talking about the power Scouting seems to have to get inside the heads and hearts of the young and produce certain miracles: for example, a discernible movement toward responsibility, a tendency to care more about others and more about *themselves,* too—the way they think, act, and talk.

In a word, we're talking about growth. A growth, stimulated by Scouting, that moves young people closer to becoming productive adults. Perhaps someday we can live in a world that is free from the scourge of child abuse and the devastation of drug abuse.

National Resources

Many communities have alcoholism counseling and drug treatment programs for youth. To find those in your area, look in the yellow pages under "Alcoholism Information and Treatment Centers" and "Drug Abuse and Addiction—Information and Treatment."

For more information about drug, alcohol, or child abuse, contact the following:

National Center on Child Abuse and Neglect
U.S. Department of Health and Human Services
P.O. Box 1182
Washington, DC 20013
703-821-2086

National Committee for the Prevention of Child Abuse
332 South Michigan Avenue, Suite 950
Chicago, IL 60604-4357
[illegible]-663-3520

National Center for Missing and Exploited Children
2101 Wilson Boulevard, Suite 550
Arlington, VA 22001
800-843-5678 (toll-free)

National Network of Runaway and Youth Services
1400 I Street NW, Suite 330
Washington, DC 20005
202-682-4114

PRIDE (Parent's Resource Institute for Drug Education). PRIDE refers concerned parents to parent groups in their state or local area and tells how to form such a group. It also provides telephone consulting and referrals to emergency health centers. Call, toll-free, 1-800-241-9746.

National Federation of Parents for Drug-Free Youth (NFP). This is a national information and referral service that focuses primarily on prevention of drug abuse by youths. It also assists anyone concerned about a child already using alcohol or drugs by referring the caller to a state or local group. Call, toll-free, 1-800-554-KIDS between 9 a.m. and 5 p.m. eastern time.

National Institute on Drug Abuse (NIDA). This national information service provides technical assistance for anyone wishing to start a drug prevention program. NIDA is focusing on the establishment of "Just Say No to Drugs" clubs. Call 301-443-2403.

NIDA Hotline. This confidential information and referral line directs callers to local cocaine abuse treatment centers. It also offers free materials on drug abuse. Call, toll-free, 1-800-662-HELP.

Cocaine Helpline. Reformed cocaine addicts offer guidance and refer drug abusers and parents to local treatment centers and family learning centers. Call, toll-free, 1-800-COCAINE.

National Council on Alcoholism and Drug Dependence, Inc. (NCADD). This national, nonprofit organization combats alcoholism, other drug addictions, and related problems through its national office, two hundred state and local affiliates, and thousands of volunteers in communities throughout America. Call 212-206-6770 (New York) or 202-737-8122 (Washington, D.C.).

BSA Local Council Service Center. See Boy Scouts of America in your telephone book.

BSA's "Drugs: A Deadly Game" Materials

- *Drugs: A Deadly Game*—eighteen-page, full-color booklet
- *Drugs: A Deadly Game*—videocassette (VHS)
- *Drugs: A Deadly Game Teacher's Guide*
- Drugs: A Deadly Game—full-color poster (23″ × 32″)—features a body chart that explains, in graphic form, the impact of drugs on different parts of the body.

Note: These items may be ordered through your BSA local council or by contacting the Drug Abuse Task Force, Boy Scouts of America, 1325 West Walnut Hill Lane, P.O. Box 152079, Irving, TX 75015-2079.

Programme on Adolescent Mental Health

SEA/MENT/129(B)
Distribution: Limited

Trainers' Guide for Adolescent Mental Health Promotion: Alcohol Use and Abuse

Health and Behaviour Unit
Department of Sustainable Development and Healthy Environments
World Health Organization
Regional Office for South-East Asia
New Delhi
October 2002

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Annexes

INTRODUCTION

Inform the adolescents that the group is going to have a session on understanding and learning about the use and abuse of alcohol.

Note to the trainer: The fact sheet on alcohol use and abuse should be distributed *after* the Session is over.

Before proceeding, please reassure the adolescents and establish the guidelines for the session:

- All responses will be kept completely confidential within the group.
- Only issues and not individual persons will be discussed.
- All are encouraged to participate and to share their personal experiences, but they have the right not to respond.
- Under no circumstances should any adolescent be allowed to laugh at or pass comments on the response of another adolescent.
- Each adolescent should listen to others without interrupting.
- There are no right or wrong answers.

Explain to the adolescents the objectives of the session, which are:

- Understand about the use and abuse of alcohol.
- Learn about the effect of alcohol on people's behavior.
- Examine the myths connected with alcohol.
- Learning how to say NO to alcohol.

Session structure:

The session is divided into two, Phase I and II. Phase I deals with understanding and sensitization of the issues on alcohol. It takes about one hour. In Phase II, the adolescents will focus on experiential learning by practical demonstration on how to stay away from alcohol.

You will need 6"x3" index cards of at least three colours, two each per adolescent, a board to paste the responses on, glue sticks, and markers. If index cards are not available, the participants can write their responses on the blackboard.

The session is based on questions and answers, discussions and role-play activities. The role-play activities can be modified to make them relevant to the local culture.

Annex 1 and 2 are to be given to adolescents for use during indicated activities.

The text is divided into six activities. Each activity has learning objectives, information to the trainer, the process to implement the activity, questions to the adolescents and possible responses. Each activity is linked to and leads to the next, so it is best to do them in order.

RAPPORT BUILDING WITH ADOLESCENTS

Learning outcomes:

The adolescents will feel reassured and comfortable, and will be able to mingle with one another and share some of their ideas about alcohol use.

Information For Trainers:

Breaking the walls between the participants as well as between the participants and the trainer is very important for the success of the session. Whatever the adolescents perceive or understand, they need a platform to share. The warm-up session facilitates the process of sharing.

Process:

Soon after adolescents enter the classroom, make them stand in a circle and ask each person:

- What is their first impression about a person who is drinking alcohol? How is it different from a person having a soft drink?
- If they were to interact with a person consuming alcohol, what kind of conversation will they have with that person, will it affect the nature of conversation?
- Ask them to narrate one behaviour of that person when he is drunk.
- How do they identify a person who is drunk?

Possible responses:

(1) First Impression:

- When I see a person drinking alcohol, I feel he /she must be very modern or fashionable.
- I think it is a sign of changing times, people drink alcohol instead of juice.
- I feel very sad for the person's family.
- I feel frightened that the person may become violent and attack me.
- I think the person is a failure in society.

- A person drinking a soft drink is simple and docile.
- Soft drinks are out of fashion and only for girls.

(2) **Interaction/conversation:**

- Conversation may be very restricted.
- Conversation may not make sense.
- There may be physical advances especially to the opposite sex.
- Cannot take what they say seriously.

(3) **Behaviour of a drunk person:**

- Using abusive language.
- Shouting.
- Criticizing.
- Incoherent speech.

(4) **A drunk person:**

- Lying on the road unconscious.
- Red eyes and foul breath.
- Cannot walk straight and keeps falling down.
- Incoherent speech.
- Vomiting.
- No self control.

Assessment of activity:

Assess if the students are comfortable with each other and with a sensitive topic such as alcohol use. If yes, proceed to the next activity. If no, try to determine what they are still uncomfortable with and spend some more time discussing these issues.

ACTIVITY 1 – DISCUSSION OF SITUATIONS OF ALCOHOL USE

Learning outcomes:

Adolescents will understand and have a mental picture of a person who abuses alcohol.

Information for trainers:

Please refer to the fact sheet and be familiar with the Section on what is harmful use of alcohol, alcohol abuse, rural alcohol consumption, impact of alcohol on women, consequences of alcohol use and what can be done about alcohol-related problems.

Process:

(A) Ask 4 adolescents to volunteer to read out one of the following case studies each:

(1) Phoolchand was the owner of a small teashop. He lived with his wife and two children. His wife, Kamala, was a housemaid. One day a group of 4 to 5 people came to his shop. They started coming regularly, and as the days passed, they became good friends of Phoolchand. He started closing his shop early, and to spend more time with them in the evening. They would sit till late at night drinking alcohol and it soon became a regular affair. As a result, he soon lost interest in work and family duties. He became an abusive husband and started hitting Kamala and his children. He no longer had control over his temper and actions. He started spending all his earnings on alcohol.

(2) There was a couple named Tony and Tanya. They were both blessed with good looks and belonged to very good families. Both were well mannered and talked very politely to everyone. Tony was a defense officer and Tanya was a housewife though she was a highly qualified women. They both regularly had social evenings and attended parties but never drank alcohol. Tanya became close friends with a senior officer's wife, who was also well educated. Tanya started confiding in her. One afternoon Tanya came running to her friend's house and began to cry and narrated the complete story of her married life, which was very different and shocking from what

it seemed to everyone. She said Tony was an alcoholic. He tortured her everyday with cigarette butts, after consuming 8 to 9 pegs of alcohol at a stretch. He was highly suspicious of her and would hit and threaten her. She was helpless and needed a solution.

(3) Mona, a good-looking, highly qualified professional woman believed that drinking alcohol reduced her stress. The stress she faced was in her professional life. She would spend a couple of hours in the bar everyday and after two or three drinks would head back home. While driving, she would sometimes get caught by the police for driving very rashly. She had several accidents. Can any solution be found?

(4) Anchal is a student of tourism and hospitality management living in a hostel. She was the only daughter of her divorced parents. She would often get calls from her mother and father, who would say bad things about the other parent. She was totally fed up with everything. She loved them both and wanted them to be together. This was a dream, which seemed far from reality. As days passed by, she began to spend more time with friends to divert her mind from tensions. She soon began to drink a glass or two of beer, which soon led to consumption of stronger alcoholic drinks. She then felt the need for it everyday and began having it in her room in the hostel. One of her friends wanted to help her but did not know what to do.

(B) Ask the adolescents the following questions on each case study:

Case study-1

- Do you know people like Phoolchand? If yes, share what you know.
- How did he get drawn into the habit of drinking alcohol when he was a happy and economically sound person?
- Should one blame Phoolchand or his friends for Phoolchand's drinking habit?
- What can be done to make Phoolchand look after his family?

Case study-2

- Tony and Tanya's behaviour in public is so deceptive. Is this the right thing for them to do?

- Does Tony hate his wife, or is alcohol perverting him to torture his wife? Can we blame alcohol for his behaviour?
- What should Tanya do?

Case study-3

- Is Mona's recourse to alcohol to release stress appropriate? Will alcohol help her?
- Can you think of other ways to release stress?
- Who would be the best person to help Mona: she herself, her friends or family?

Case study-4

- How does Anchal feel about her parents criticizing each other? Is it common in many houses?
- Can Anchal concentrate on her studies?
- How can Anchal's friend help her to get out of the habit of consuming alcohol?

(C) Ask them:

Do you feel Phoolchand, Tanya, Mona and Anchal would be able to function effectively and efficiently if they were to give up alcohol?

(D) Possible responses:

Case study 1

- Yes, we know of many people like him, my maid's husband is like that.
- People initially start drinking during a ceremony or festival. Sometimes, they join a group of friends. However, some people begin to drink alcohol regularly.
- May be, his friends pressurized him.
- One should blame both, Phoolchand and his friends for Phoolchand's drinking habit.
- Counselling can be done, Phoolchand can go to a de-addiction centre, sometimes religious centres can help.

Case study 2

- Tony is trying to keep his bosses happy and not know his bad habits. Tanya should not tolerate this behaviour, she should try to get help for her husband.
- A person is not responsible for his behaviour when drunk. TRAINER: Discuss: Drunk or not drunk, a person, is responsible for his behaviour.
- Tanya should become stronger and needs support to be assertive and not take any nonsense.

Case study 3

- Mona is stressed because of her work. This is what international competition has done.
- She wants to compete and be professionally good.
- Alcohol will ruin her, not relax her.
- She can go for a walk, or workout or read or do social work.
- Mona, herself, her friends and family can all help in their own way.

Case study 4

- After a bitter divorce, people often criticize the other spouse.
- It will be very difficult for her to continue her studies, but somehow she must think of herself.
- Anchal's friends and other relations may be able to help her.

Assessment of activity:

Ask the adolescents if they have a mental picture of a person who uses too much alcohol and some of the harmful effects from alcohol abuse. If they have no further questions, proceed to the next activity.

ACTIVITY 2 – UNDERSTANDING ABOUT ALCOHOL AND ALCOHOL ABUSE

Learning outcomes:

The adolescents will understand about alcohol and alcohol abuse.

Information for trainers:

Please refer to the Fact Sheet and be familiar with the Section on what is alcohol, what is harmful use of alcohol, alcohol abuse, impact of alcohol on women, different types of alcohol and their equivalent strengths, harmful effects of alcohol.

For this activity, you may wish to give the participants the information in the fact sheets by writing it on the board. It is unlikely that adolescents will already know the specific details about alcohol, its use and abuse.

A scientific discussion on this topic is the best way to inform children about alcohol and its harmful effects.

Some common signs and symptoms of alcohol abuse

- Absence from school or work.
- Depression or unhappiness.
- Drinking in order to cope with personal problems.
- Drinking to overcome shyness.
- Loss of interest in family and friends.
- Loss of interest in activities which were once of interest.
- Difficulty in sleeping.
- Poor judgment.
- Drinking outside of a social setting.
- Showing up intoxicated in inappropriate settings.
- Drinking to build self-confidence.
- Mood fluctuations.

- Developing health problems.
- Experiencing memory blackouts during or after drinking.
- Usually drinking to the point of intoxication.
- Feeling guilty about drinking.
- Not fulfilling promises or obligations.

Can a person determine if they themselves are drinking too much alcohol?

A person can benefit greatly from simple introspection on whether increased alcohol consumption could be affecting his/her life. Four simple questions which comprise the CAGE test can help a person decide whether he/she may have an alcohol-related problem. If the answer to two or more questions is 'yes', there is a strong likelihood that the person needs help for the alcohol-related problem and must seek help.

The CAGE test:

Cut down	1	Have you ever felt that you ought to cut down on your drinking
Annoyed	2	Have people annoyed you by criticizing your drinking?
Guilty	3	Have you ever felt bad or guilty about your drinking?
Eye Opener	4	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Another simple question which can help a person decide if they may have an alcohol-related problem is to ask themselves, "Do I **need** a drink?" This question may seem too simple, but if the honest answer is "yes", it suggests that alcohol is affecting a person's daily life to the point that they cannot optimally function without it. This is a good indication to seek help for their alcohol-related problem.

Process:

Please address the following questions:

- What is alcohol, what are the different types of alcohol?
- What is alcohol abuse?
- What is alcohol dependence?
- Can beer be as harmful as whisky?
- Do you think alcohol is a problem for young people?
- Is alcohol a problem for poor people?
- Are women more vulnerable to adverse effects of alcohol?
- What does alcohol do to your body?
- Is it safe to drink and drive?
- Describe some common signs and symptoms of alcohol abuse.
- Is it possible for a person to determine if they themselves are drinking too much alcohol?
- Ask the adolescents to list how many medical complications of alcohol they are aware of.
- Ask the adolescents to list financial, occupational, familial, social and legal complications of alcohol use.

Assessment of activity:

Ask the adolescents if they understand the harmful effects of alcohol use and the term alcohol abuse. Please make sure that all their questions are adequately addressed. If there are no further questions, proceed to the next activity.

ACTIVITY 3 – EFFECTS OF ALCOHOL ON THE BODY

Learning outcomes:

The adolescents will get sensitised to how alcohol affects the body and the effect of various amounts of alcohol on bodily function. Information on harm that can occur after consumption of different amounts of alcohol should be emphasized.

Information for trainers:

Please refer to the Fact Sheet section on acute intoxication due to use of alcohol. It is very informative for adolescents to know the meaning of "blood alcohol concentration" (BAC).

Process:

Please describe to them some real life examples of what can happen at each level of intoxication.

Effects on the body at different blood alcohol concentrations (BAC)

Blood alcohol concentration	Effect on the body
20-30 mg/dl	Slight euphoria, extrovert behaviour, slight decrease in analytic capability, slight impairment in skilled function, increased risk-taking behaviour.
30-80 mg/dl	Moderate impairment of balance, speech, reaction time and vision, judgement and self control reduced, reasoning ability diminished.
80-200 mg/dl	Definite impairment of motor function and judgement. Fluctuations in mood and increased risk-taking behaviour, dangerous driving.
200-300 mg/dl	Marked slurring of speech, inability to carry out even simple tasks, needs assistance in walking, severe mental confusion.
> 300 mg/dl	Loss of consciousness, convulsions and possible death

Assessment of activity:

Ask the adolescents if they understand about the effects of alcohol on the body. If you are satisfied that they have understood, proceed to the next activity.

ACTIVITY 4 - MYTHS AND MISCONCEPTIONS ABOUT ALCOHOL

Learning outcomes:

Adolescents will learn about myths and misconceptions and the facts about alcohol.

Information for trainers:

Most of us have some preconceived notions about alcohol. Some of these notions are not true. These myths cloud our thinking and prevent us from accepting the dangers of alcohol when it affects us, our friends or family. By dispelling these myths, one becomes aware of the reality and can be motivated into action.

To distinguish between a myth and a fact, accurate information is necessary. There are many myths and beliefs surrounding the use of alcohol and these need to be corrected.

A **myth** is a widely held belief that is assumed to be true but which has either not been tested or which has been tested and found to be false. A fact is an idea, an event, or an experience, which has been tested and found to be true The evidence for the truth of a fact can come from many sources - scientific research, historical evidence, common experience, physical evidence, etc.

Do not tell the adolescents that the statements being read are myths. Make sure they read the statements and understand what is being said.

MYTHS

➢ He's too nice to be an alcoholic.	➢ Women can't be alcoholics.
➢ He only drinks beer.	➢ She's too young to be an alcoholic.
➢ He only drinks after work.	➢ I never see him drink.
➢ He's not always drunk.	➢ She's too intelligent to be an alcoholic.
➢ He seldom misses work.	

Process:

- Make the adolescents stand in a circle.
- Give each of them a card with a myth printed on it.
- Tell them that they should read it one by one.
- Facilitate a discussion on each myth, after it has been read. Some probing questions to facilitate discussion can include:
  - What do you think about what was said?
- Do you believe what was said is correct?
  - Why do you feel the way you do?
  - Who says such things?
- Each adolescent who desires to agree or disagree with a statement should be given an opportunity. Special attention should be given to the source of the idea expressed by the adolescent. From the discussion it will appear that some adolescents agree with the statement and some do not. Exploring why adolescents believe what they do believe is important in dispelling the myths. Scientific discussion and facts should be used in trying to correct what they believe incorrectly.
- After some discussion, record a vote of what the adolescents believe about the statements concerning alcohol. Do not give the correct answers, but keep the record until the end of the discussion.
- Finally, show the true statements taken from the table below.
- Discuss the myth and fact together.

Myths and Facts about alcohol:

Myth: Alcohol stimulates a person to become more lively.

Fact: Alcohol is actually a depressant of the brain and its function. There is a common belief that it removes (depresses) inhibitions. Careful observation has shown that "removing inhibitions" happens before alcohol levels in the blood reach a noticeable threshold. Thus, the real reason for "removing inhibition" appears to be anticipatory learned behaviour.

Myth: People who become aggressive and violent after alcohol use cannot control their behaviour because it is caused by alcohol's action on the brain.

Fact: Many people learn to associate certain moods and behaviours with the alcohol effect and behave in a manner in which they wish to behave. The behaviour then becomes 'conditioned'. People can learn to change the conditioning. .

Myth: Alcohol enhances sexual performance and desire.

Fact: Shakespeare's quote that alcohol 'provokes the desire but inhibits the performance' is well-known. Alcohol interferes with achieving erections. In research studies, alcohol has been shown even to reduce sexual desire.

Myth: Alcohol promotes good sleep.

Fact: People dependent on alcohol cannot sleep well without alcohol. Those who do not use alcohol regularly may have disturbed sleep after alcohol consumption.

Myth: Alcohol helps people to forget their problems.

Fact: This has become a 'truth' because regular and heavy alcohol users often say this is the reason why they drink alcohol. Very often the opposite is found to be true – people bring up forgotten problems only when they are intoxicated.

Myth: Alcohol is a good way to cope with cold weather.

Fact: Alcohol dilates blood vessels and makes the skin feel warm. But in a cold environment, the body tries to save heat by cutting down the blood supply to the skin. Thus alcohol is not a good way to "warm up" in the cold. If a person is exposed to the cold after consuming alcohol, there can be significant heat loss from the body.

Myth: Beer is not "hard liquor", so it can be consumed safely.

Fact: Beer is an alcoholic beverage, although it contains a lesser amount of alcohol than "hard liquor" like whisky or rum. Beer contains 4 to 8 per cent alcohol. One 12-ounce bottle of beer is equal to one peg of whisky. Thus, if somebody drinks six bottles of beer in an evening, he/she has consumed the equivalent of six pegs of whisky.

Myth: Alcohol has been shown to be "good for the heart", so one should drink alcohol every day.

Fact: There is some research which has shown the potential protective effect of alcohol on the heart. This research has been based on consumption of small

amounts of alcohol, mostly wine on a daily basis. Consumption of alcohol on a daily basis is a matter of concern, as some people cannot control the quantity of alcohol consumed. Consumption can gradually increase to dangerous levels. Heavy alcohol consumption is certainly bad for the heart and the body.

Myth: He is really a good man, it's the alcohol which makes him abuse me.

Fact: When a woman is beaten by a husband while he is sober, she may consider this as unacceptable. However, if he behaves in exactly the same manner after drinking, she may forgive him and blame alcohol. Society's view of intoxicated people makes it less risky to behave deviantly while intoxicated. However, projects on prevention of harm from alcohol have shown that if society will not tolerate unacceptable behaviour with or without alcohol, such behaviour ceases. An unacceptable behaviour is unacceptable, with or without alcohol.

Myth: In our society, alcohol 'loosens up' people, so they enjoy themselves.

Fact: Most societies have set the norms for un-inhibited behaviour while intoxicated. People appear to adhere strictly to these norms and rules. The 'uncontrolled' impulses appear to be controlled by society's instructions about the effects of alcohol upon behaviour. Thus, people learn about drunkenness from what their society "knows" about drunkenness.

Myth: If your friends are drinking, you have to drink to have a good time with them.

Fact: Behavioural research has documented that in a group drinking alcohol, even those who are not drinking can have an equally good time and behave in the same uninhibited manner. Adolescents call this "getting high on other people's alcohol".

Assessment of activity:

Ask the adolescents if there are any other beliefs about alcohol which they would like to discuss. If not, proceed to the next activity.

ACTIVITY 5 - IMPACT OF ADVERTISEMENTS

Learning outcomes:

Adolescents will be able to understand the impact of advertisements on the community's consumption of alcohol and its effects.

Information for trainers :

Alcohol advertising is a big business for the alcohol industry. The objective is to glamourize alcohol and link it to "modern lifestyle" or "having a good time". Alcohol companies sponsor many popular events such as sports events. Many countries have banned the advertisement of hard liquor on television. Some have banned advertisements in the print media and bill boards as well. A few countries have a complete ban on advertisement of hard liquor. However, policies on advertising beer and wine are much more liberal. A new phenomena is surrogate advertising, in which mineral water or even juice is shown in bottles resembling liquor bottles. This leads to brand identification and indirect promotion of hard liquor.

Advertising to young people is a crucial activity for the alcohol industry. This age group is the "prize" they all hope to capture as future consumer. The World Health Organization recognizes that advertising alcohol to young people is a serious problem.

The discussion should help adolescents understand that advertisers are tempting them to buy their products.

Process

- Ask the adolescents where they find advertisements for alcoholic beverages?
- Ask them to bring the cuttings of advertisements and pin them up for a discussion.
- Discuss the message that runs through all the advertising events.

- What do the advertisements fail to tell us?
- How do their brothers and sisters react when they watch advertisements?

Possible responses:

Shops, newspapers, magazines, television and on shops.

The messages in the advertisements are as follows:

- Alcohol enhances social status.
- Alcohol is equal to success.
- Alcohol is necessary in social settings.
- One should drink alcoholic beverages.

What do the advertisements fail to tell us?

- The dangers of alcohol use.
- The hazards of driving after drinking.
- Drunkenness.
- Becoming ill.
- Being a social nuisance.
- Fighting.
- Arguments.
- Long-term physical effects.
- Long-term social effects (social breakdowns, loss of job etc.).

Influence of advertisements:

Adolescents try to copy what they see.

Assessment of activity:

Ask the adolescents if they understand the impact of advertising on alcohol use in the community, particularly how advertising impacts consumption of alcohol by adolescents. If there are no other issues to discuss, proceed to the next activity.

ACTIVITY 6 - ROLE PLAY: HOW TO SAY NO TO ALCOHOL

Learning outcomes:

Adolescents will learn to assert themselves and say "NO" to alcohol.

Information for trainers:

Role-play is an important component of experiential learning. It will help adolescents to actually learn about alcohol. Before they can say "NO" to alcohol, it is important for adolescents to understand why people drink alcohol. So before, they can learn to exert themselves, make them understand the pressure on them to drink.

Process:

Divide the class into four groups. Give each group one issue related to "who decides whether I should drink alcohol". Make each group read out the question and discuss the possible responses.

Now give each group one situation and allow them to develop a role-play from the given situation. They should be as creative as possible. After the role play facilitate a discussion on how it helped them to understand the situation and also tell them that they should be able to find ways of asserting themselves and saying "NO" to alcohol.

Possible responses:

Who decides whether people should drink alcohol?

- They themselves.
- Their friends.
- The community acceptance (it is OK for boys of a certain age to drink alcohol).

Why do people drink alcohol?

- They are consuming alcohol because they want to and like it .
- Someone else has taken the decision for them to drink, even though they prefer not to.

What is the image of alcohol and alcohol users?

- A person who has grown up.
- Adventurous.
- Defiant/like to break rules.
- Graduated from soft drinks.
- Member of a fraternity.
- High social status.

How do advertisements influence us?

- They create a glamourous image.
- Tell us there is nothing wrong with it.
- Makes us identify with actors and sports stars.
- Encourages us to consume alcohol.

Situation: 1

Jeevan is a 16-year-old boy and the only child of a poor family. He is very close to his mother who suffers from a dreaded disease. His mother has not told him about her problem. One day she sends him to get a very important medicine but Jeevan spends the money on alcohol due to peer pressure. When he returns home, he realizes that his mother is desperately in need of that medicine without which she is unable to breathe. He finds himself full of guilt and remorse.

Situation: 2

Meera a 15-year-old girl who lives with her alcoholic father who abuses her mother physically and mentally. The situation worsens to such an extent that one day she persuades and convinces her mother to leave home with her. She obtains help from some nearby social service groups.

Situation: 3

Raja and Rani were in love with each other and were seen by others as made for each other couple. Raja who used to occasionally drink soon became a compulsive alcoholic. Due to continuous stress in his work place and his reduction of the ability to regain self-control as a result of alcohol, he lost his job and also started abusing Rani physically. Rani did not know how to assert herself and stop his drinking habit.

Situation: 4

Deepak and Mohan, senior school students tried to bully a couple of junior adolescents to consume alcohol and also threatened them in different ways, if they disobeyed. At the same time, Ram and Shyam of the same class came forward and rescued the juniors and won the heart of others in school. How could they do that? They also managed to help Deepak and Mohan by sending them to a counsellor.

Possible responses on how to evade the pressure – please see Annexes 1 and 2.

Assessment of activity:

Discuss with the adolescents if they would be able to evade the pressure to consume alcohol, particularly when it is against their wish.

CONCLUSION:

Discuss any issue about alcohol use and abuse which the adolescents may want to discuss, so that, at the end of the session, they clearly understand the hazards of alcohol use and abuse.

Annex 1

WAYS TO SAY NO

Method	Persuader	Decider
Polite refusal	"Can I get you a drink?"	"No, thanks".
Give reason	"How about a beer?"	"I don't like beer"
Be firm	"Here, smoke this joint with me"	"No, thanks"
	"Come on!"	'No, thanks".
	"Just try it, chicken	"No, thanks".
Walk away	"Hey, do you want to buy some brown sugar"?	Say 'no' and walk away after you say it.
Cold shoulder	"Do you want some brown sugar"?	Keep going as if you did not hear the person. (Not the best to use with friends).
Give an alternative	"Let's go upstairs to my room"	"I'd rather stay here and watch T.V".
Reverse the pressure	"Come on, just upstairs with me"	"What did I just tell you? Were you listening?"
Avoid the situation		If you know of people or situation where people will pressurize you to do things you don't want to do, stay away from these situations.
Strength in numbers		Hang around with people who support your decision not to drink, use drugs, etc.
Own your feelings		"I am not comfortable doing this". "It makes me unhappy".

Annex 2

STEPS IN REFUSING

Situations:

- An invitation to drink.
- An invitation to smoke.
- An invitation to skip the class.
- An invitation to go out at night.
- An invitation to spend a night at a friend's house.

Steps in refusing:

- Tell your friend what you feel and the reason why you feel so. Most friends would listen to your reasons.
- Refuse clearly.
- Ask your friend's opinion on his invitation to show that you have not rejected it outright. Thank your friend if he accepts your refusal.
- In case they insist and are insulting, you should try not to pay attention to their words. Instead, try to concentrate and think how to avoid going with him as follows:
  - Repeat your refusal, say good bye, and start walking away.
  - Negotiate with him, and invite him to do some other activities.
  - Postpone your answer in order to change your friend's intention.

Alcoholism & the Family

Donald E. Meeks, DSW

An "alcoholic" is a person who, as a result of the abuse of alcohol, is experiencing serious and recurring personal and social problems or health damage, and who, because of these problems, would benefit from treatment. However, there is a wide range of personal styles and consumption – including occasional light drinking and constant heavy drinking – and the shadings between different levels of consumption are imperceptible. Thus there is no clear line of separation between "hazardous drinking" and "alcoholism."

Although the terms "alcohol dependence" and "alcohol dependent person" are more accurate, "alcoholism" and "alcoholic" are widely recognized words in popular and even clinical use, and are therefore used throughout this pamphlet.

ALCOHOLISM AND THE FAMILY

by Donald E. Meeks, DSW

An alcoholic's family is often seen as both the cause and victim of the drinking problem. While it may be true that family pressures had a hand in the early development of the alcoholic, it is also true that the family shares in suffering the consequences. Clearly, problem drinking affects and is affected by family behaviors and relationships which can help the alcoholic regain and maintain sobriety or, alternately, make recovery even more difficult to attain.

Often, families undergo drastic internal reorganization in attempting to cope with a problem drinker in their midst. The usual responsibilities undertaken by the drinker are reassigned to others, a situation resented by the alcoholic, who feels, and perhaps is, excluded from the healthy relationships that would normally exist in the family. The problem drinker also may experience guilt from letting the family down. Whatever the surface appearances, anger, tension, and resentment are usually part of the family picture.

Children as well as adults become increasingly torn by anxiety and conflict and may be forced to take sides. They may be required to play adult roles such as caring for younger brothers and sisters, and they are sometimes expected at early

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ages to contribute to the family income. At times they may fear for a parent's safety or for their own, and they are often unwilling or ashamed to bring friends home.

A child in the family of an alcoholic may develop troubles seemingly unrelated to the drinking but which arise directly from the anger, resentment, and confusion at home. Underachievement at school, aggressiveness, or sullen and withdrawn behavior are not unusual.

As commonly painted, the marital partner and children of a problem drinker are victims of the problem. While this may be true, it may also mislead the family in its efforts to resolve its problems. In order to interrupt the destructive cycle, the behavior of every family member, including the drinker's, should be examined. Despite popular beliefs, children as well as adults may be drawn into and become part of the destructive pattern. In short, to restore healthy functioning, it may be necessary for the family as a whole to change.

Since all family members are affected by problem drinking, all must carefully examine how what they do is affected by the drinking and how their actions in turn affect the drinker and the drinking. The family may require help from a source outside itself in order to assist in this process. The necessary steps to take involve confronting the problem, seeking help, trusting the counselor, engaging in the helping process, dealing with setbacks, and finally, adjusting to recovery.

CONFRONTING THE PROBLEM

It is sometimes difficult to distinguish problem drinking from heavy social drinking, a confusion that may serve as a shield for the alcoholic. If heavy drinking is frequent, or if there are medical, financial, employment, legal, or other problems

occurring as a result of the drinking, then the situation constitutes a problem. Acceptance of such a drinking problem is fraught with anxiety. The common questions are: Will the problem not go away if we ignore it? Is this an indication of mental illness? Will the drinker have to be hospitalized? What will the boss say and do? What will family, friends, and neighbors think?

The answers to these questions are not necessarily simple. Seldom does a drinking problem disappear when it is simply ignored. While excessive drinking is not in itself a mental illness, emotional conflicts may cause or be caused by it. Indeed the problem may be treated as an illness when the emotional conflicts are triggered by drinking that is out of control, i.e. when the drinker can no longer limit how often the drinking is done, where it is done, or how much is drunk.

If medical problems are present or if the person cannot stop drinking in his or her natural surroundings, hospitalization may be necessary. However, this is true for only a small percentage of alcoholics.

An alcohol problem does test the depth of friendships, and friends who remain loyal can provide a great deal of needed support. But, inevitably, some acquaintances may be lost as a result of the problem. Fear of what others may think or do can stand in the way of seeking help. This is often the case with people who hold a job. It is unlikely that a severe drinking problem can exist without some problems occurring on the job. Decreased efficiency, lateness, and absences accompanied by any excuse except the true one are very common. It is encouraging, however, that a growing number of employers accepts the fact that salvaging a good employee is better than starting with someone new. Many programs have attempted with some success to involve employers and the trade unions in the helping process.

It would be unrealistic to suggest that no risks will be involved in the open acknowledgement of a drinking problem. However, the risks must be weighed against the consequences of not confronting the problem head on. Often a drinking problem is hidden or denied in a misguided effort to protect the drinker and the rest of the family. Hiding or not facing the problem allows it to get worse, whereas early efforts to seek help may protect the drinker and the family from further damage.

SEEKING HELP

When the family members accept the problem for what it is, they must then decide what action to take.

Each community has within it, or nearby, programs established specifically to help alcoholics. Some programs are staffed by professionals; others, such as Alcoholics Anonymous, are operated by persons who have experienced alcohol problems themselves. Again, the sooner one seeks and obtains help, the better the prospects for reducing damage caused by the problem.

Often the alcoholic is the last member of the family to accept the existence of a serious drinking problem and the need for help. In this case the wife, or husband, and other relatives should seek help for themselves. Since the alcoholic is not the only one confused and troubled by the drinking, help can be used to advantage by other members of the family, and it should include advice about ways to involve the alcoholic in the helping process.

TRUSTING THE COUNSELOR

In the beginning it is sometimes difficult to share intimate thoughts and feelings with a stranger, but it is important to give information freely and openly to the counselor. Conflicts, fears, and anxieties must be clearly understood in order for them to be dealt with effectively.

Helping agencies attempt to select people with the qualities needed to encourage trust and confidence. Counselors are aware of the intimate, confidential nature of the information they are given, and they are bound by their own ethics and by law to keep the information confidential. They are also aware

that their job is not to judge but to understand and to offer the best help possible. All of this should reassure the client that counselors can be trusted. If the counseling process is to be sincere, open, and productive, trust is a necessary ingredient.

ENGAGING IN TREATMENT

Involving everyone in treatment not only helps the alcoholic but assists other family members in dealing with their own conflicts, anxieties, fears, and confusion. Often individual treatment is required to help the alcoholic stop drinking and start on the road to recovery. While this is going on, other members of the family may be counseled separately to help them understand and deal with their problems.

Marital counseling or family therapy may begin when the alcoholic is sufficiently recovered and able to participate. Marital counseling usually involves the couple with a counselor and attention is given not only to the drinking but to other problems in the relationship – at home, at work, and in the community.

Family therapy involves the total family who shares a common household, including children old enough to participate. Parents may be reticent about discussing the problem in front of children but in family therapy they may discover for the first time how much the children already know and how deeply they are concerned. These therapy sessions provide a safe, reassuring atmosphere in which the children can talk about their feelings and contribute to the solution of family problems.

Family therapy helps families discover ways in which the total family can establish a healthier, more satisfying life, including ways in which the family can support the alcoholic's efforts to stay sober.

DEALING WITH SETBACKS

A drinking problem that has taken years to develop will not be resolved overnight, even with treatment. The drinker and the family should be prepared for a long and difficult process. Some drinkers, once sober, never drink again. They are able, over a long period of time, to reassemble their lives and resume family and work functions. In other cases, the alcoholic may begin to drink again with accompanying deterioration in work, social life, and family relationships.

All involved – family, counselors, friends – must exercise patience. Moreover, they must accept the drinking relapse as part of a difficult process. Rather than reacting with despair or defeat, the family and others involved can help the drinker return to sobriety. Often one or several drinking relapses may be experienced before a firm recovery is accomplished.

ADJUSTING TO RECOVERY

A common belief is that once the drinking stops all family problems disappear. On the contrary, attaining sobriety is but one step in that direction. During the subsequent recovery, family members must adjust to each other on a new basis and new problems may emerge. Roles and functions undertaken by the spouse and children during the drinking period, while

they may have been burdensome, also probably provided some satisfaction. For example, older children may have been coerced into the abnormal role of pseudo-parent to younger brothers or sisters, or the wife or husband may have had to assume the other's duties – financial, household, etc. – as well as their own.

New ways must be established to give and receive emotional support both to the recovering alcoholic and to adjusting family members. The adjustment may be complicated if the family members distrust the recovered alcoholic's ability to remain sober. They may fear giving up their acquired responsibilities with their relative security for the perhaps faint hope that this time the drinker will stay sober. Restoring trust is not easy. But it is necessary.

Problems which had been considered as part of the drinking problem may surface during the recovery period. Lack of communication, an unsatisfactory sexual relationship, mismanagement of finances, or difficulty in disciplining the children can no longer be blamed on the drinking. Each problem must be faced and dealt with on other terms. Far from being a time when help is no longer required, recovery can be a stage where adjustment is difficult and help is essential.

SUMMARY

Families of alcoholics are affected by and affect a drinking problem. In order to help the alcoholic recover and stay sober it is sometimes necessary to assist the family in changing some of its ways of doing things. Help for families is aimed not only at assisting the alcoholic member but also at enabling other family members to deal with their problems.

Family adjustment to a drinking problem is usually accompanied by anger, tension, and resentment. Problems in the home may have been triggered by the drinking. Children as well as adults experience confusion, anxiety, and conflict. As the pattern of destructive behaviors develops, all members of the family may contribute to family problems. In order to help, it is necessary to examine all family behaviors.

Usually, the family of an alcoholic requires help from a source outside itself. Aid may be sought from a clergyman, a family physician, a self-help group such as Alcoholics Anonymous, or from a professional helping agency. Seeking help requires squarely accepting and confronting the problem and making a decision to act. Refusing to face the problems makes them worse. In order to achieve full benefit from outside help it is important to openly and honestly share information, feelings, and concerns. The quality of counseling is only as good as the sincerity and openness of the people involved.

Therapy and counseling may take different forms. Initally, the alcoholic may require a period of individual therapy. This may be followed, if appropriate, by marital counseling with the couple or by family therapy. Family therapy includes children old enough to participate. Children are more aware of and more deeply affected by alcohol problems than is usually suspected. The aim of such therapies is to help family

members understand and deal with their problems in order to improve family life for all of its members.

An alcohol problem takes a long time to develop. It will not be resolved overnight. Time and patience are required to work through a variety of related problems. In the process, setbacks such as a brief or extended return to drinking may occur. Such setbacks should not be considered as a total failure. All involved must help the alcoholic again return to sobriety.

With recovery, all problems cannot be expected to magically disappear. The family must adjust to having the recovered alcoholic back as a full member in the family circle. It must deal with some problems in the relationship that were previously blamed on the drinking. Adjustment to recovery may be difficult and help at this stage may be essential.

Some sources of help and information for families with problems that involve misuse of alcohol are listed below. This list is not intended to be comprehensive, but it does provide basic contacts available in most communities.

Alcoholics Anonymous, Al-Anon, Alateen

Children's Aid Society

Clergyman

Doctor

Family Service Association

Hospital

Medical Office of Health

Government – Community and Social Services

Salvation Army

Social Planning Council

Victorian Order of Nurses

Welfare Office