RF_MH_2_C_SUDHA

MH-2c.1

T T RANGANATHAN CLINICAL RESEARCH FOUNDATION
"TTK HOSPITAL"
17,4th Main Road,Indira Nagar,Madras-600 020

COGNITIVE CAPACITY SCREENING EXAMINATION

Patient Name: Sex:M or F

Age Education Occupation

Occupation Date Date

Orientation Place

1. What day of the week is this? ____________
2. What month? ____________
3. What day of the month? ____________
4. What year? ____________
5. What place is this? ____________
6. Repeat the numbers 8 7 2 ____________
7. Say them backwards ____________
8. Repeat these numbers 6 3 7 1 ____________
9. Listen to these numbers 6 9 4.Count 1 through 10 out load, then repeat 6 9 4. (Help if needed, Then use numbers 5 7 3). ____________
10. Listen to these numbers 8 1 4 3. Count 1 through 10 out load,then repeat 8 1 4 3 ____________
11. Beginning with Sunday, say the days of the week backwards. ____________
12. 9 + 3 is ____________
13. Add 6 (to the previous answer or to 12"). ____________
14. Take away 5 ("from 18"). Repeat these words after me and remember them, I will ask for them later:HAT,CAR,TREE, TWENTY-SIX. ____________

15. The opposite of fast is slow. The opposite of up is ______

16. The opposite of large is ______

17. The opposite of hard is ______

18. An orange and a banana are both fruits. Red and blue are both ______

19. A penny and a dime are both ______

20. What were those words I asked you to remember? (HAT) ______

21. (CAR) ______

22. (TREE) ______

23. (TWENTY-SIX) ______

24. Take away 7 from 100, then take away 7 from what is left and keep going: 100 - 7 is ______

25. Minus 7 ______

26. Minus 7 (write down answers; check correct subtraction of 7) ______

27. Minus 7 ______

28. Minus 7 ______

29. Minus 7 ______

30. Minus 7 ______

TOTAL CORRECT (maximum score = 30) ______

MH-2c.2

T T RANGANATHAN CLINICAL RESEARCH FOUNDATION
IV MAINROAD, INDIRA NAGAR, CHENNAI 600 020

Name: Age: Date

The following statements are intended to indicate your interest and attitudes. This is not an intelligences test and there are no right and wrong ansers. Draw a circle around "T" if the corresponding statement is true and around "F" if it is false. If you are not sure, guess.

1.	I often get red spots on my neck	True/False
2.	I like to be praised by my superiors	True/False
3.	I enjoy many different kinds of play and recreation.	True/False
4.	I have never fainted or felt like fainting	True/False
5.	I have used alcohol excessively	True/False
6.	I would like to be a nurse	True/False
7.	My parents were generally reasonable in making me obey	True/False
8.	I easily become impatient with people	True/False
9.	Peculiar odours (smells) come to me at times	True/False
10.	The top of my head sometimes feel tender	True/False
11.	My soul sometimes leaves my body	True/False
12.	I do not always tell the truth	True/False
13.	I usually feel that life is worthwhile	True/False
14.	I enjoy detective or mystery stories	True/False
15.	I have very few quarrels with members of my family	True/False
16.	I am interested in the latest fashions in clothes	True/False
17.	I feel that I have often been punished without cause	True/False
18.	I don't like to study about things that I am working at	True/False

T T RANGANATHAN CLINICAL RESEARCH FOUNDATION
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18. I don't like to study about things that I am working at True/False

19. I have never been in love with anyone — True/False

20. I often have feelings like nurning, tingling, or crawling — True/False

21. I am not afraid to handle money — True/False

22. I do not like everyone I know — True/False

23. I brood a great deal — True/False

24. I am worried about sex matters — True/False

25. My comfort comes before that of others — True/False

26. I like mechanics, (dealing with machines, automobiles, etc.) magazines - popular or otherwise — True/False

27. I have had more thanmy share of things to worry about — True/False

28. I forget right away what people say to me — True/False

29. I dislike having people around me — True/False

30. I have a great deal of stomach trouble — True/False

31. It does not bother me particularly to see animals suffer — True/False

32. Sometimes I put off until tomorrow what I should to today — True/False

33. I do not worry about catching diseases — True/False

34. Many people exaggerate their trouble to gain sympathy — True/False

35. I would rather enjoy the present than plan for a future — True/False

36. I am not interested in science — True/False

37. I have no enemies who really wish to to harm to me — True/False

38. Unimportant throughts sometimes bother me for days — True/False

39. Most of the time I wish I were dead — True/False

40. I am usually calm and not easily upset — True/False

41.	I get angry sometimes	True/False
42.	I would rather win than lose in a game	True/False
43.	Once in a while I laugh at a dirty joke	True/False
44.	When in trouble I keep my mouth shut	True/False
45.	I have very few fears compared to my friends	True/False
46.	I never liked to play with dolls	True/False
47.	I am sure I am being talked about	True/False
8.	I get upset when I have to make a short trip away from home	True/False
49.	I often feel as if things were not real	True/False
50.	I often feel pain in the back of my neck	True/False
51.	I can sleep during the day but not at night	True/False
52.	Sometimes when I am not feeling well I get annoyed easily	True/False
53.	I am easily awakened by noise	True/False
54.	My eye sight is as good as it has been for years	True/False
55.	There is very little love and companionship in my family	True/False
56.	I like adventure stories better than romantic stories	True/False
57.	I think I feel more intensely than most people do	True/False
58.	I must stop and think even before doing simple tasks	True/False
59.	Many of my dreams are about sex matters	True/False
60.	I have no difficulty in holding or moving my bowels	True/False
61.	A priest or a religious man can cure disease by putting his hand on hour head	True/False
62.	I am not always prompt	True/False

63. I go to temple or church regularly True/False

64. My sleep is fitful and disturbed True/False

65. I have been quite independent and free from family rule True/False

66. I would like to tend a flower garden True/False

67. Evil spirits never possess me True/False

68. I often cross the street to avoid someone I see True/False

69. I get all the sympathy I should True/False

70. I have had no difficulty holding or starting my urine True/False

71. I believe in law enforcement True/False

72. Once in a while I have broken a promise True/False

73. Criticism or scolding hurts me terribly True/False

74. My home life is as pleasant as that of most people True/False

75. I liked school True/False

76. I like poetry True/False

77. I don't believe that anyone is plotting against me True/False

78. I have a habit of counting unimportant things True/False

79. I hear things when I am alone True/False

80. I have had several operations which did not benefit me True/False

81. Sometimes I feel that I must injure myself or someone else True/False

82. I gossip a little at times True/False

83. When I leaved home I do not worry if I locked the door True/False

84. My conduct is controlled by the customs around me True/False

85. I have not lived the right kind of life True/False

86. I like to cook True/False

87. Someone has control over my mind True/False

88. Bad words come to my mind and I can't get rid of them True/False

89. Sometimes I enjoy hurting people I love True/False

90. I enjoy social gatherings just to be with people True/False

91. Some persons try to steal my thoughts and ideas True/False

92. At times I envy successful people True/False

93. I work under a great deal of tension True/False

94. The sight of blood neither frightens not makes me sick True/False

95. Lust for pleasure often gets me into trouble True/False

96. I often wish I were born of opposite sec True/False

97. I am on guard with people who are too friendly True/False

98. I do not dread going into a room where a people have gathered suddenly True/False

99. At times I have enjoyed being hurt by someone I love True/False

100. I cannot do anything well True/False

MH-2c-3

CASELETS (CAMP)

1) ***The counsellor has to select a campsite. Which of the following would you recommend?***

a) The Counsellor was assessing the new camp site. The building was situated on the outskirts of the town and the atmosphere was peaceful. The newly built building was bright and airy. Water would be brought in from the town daily and arrangements had already been finalised.

b) A voluntary organisation - 'Ladies Club' is part of an industry. It was run by the wives of the executives of the industry. The women were interested in conducting a camp for the villagers. The President assured, "We will provide the marriage hall to conduct the camp. From our fund, we will organise meals for the patients. Our ladies club members can conduct bhajans in the evenings. One thing we find difficult is to identify and select patients. We can recommend 10 patients who are husbands of our house maids. The rest 15 you may have to select.

2) ***Which of the following organisations will you choose to conduct the camp?***

There were two host organisations in the same village. One organisation had a team of helpful, committed volunteers. The organisation was known for a lot of welfare activities in the area - free schools, dispensaries, providing free noon meal to children under 10 years, running cyclone relief units during natural calamities etc.

The second organisation was involved in organising Micro Credit System for women. They had experience in conducting medical camps with the help of doctors from the neighbouring areas. This organisation was never involved in providing free meal to children or providing free medicine to villagers.

3) ***The screening / interviewing is on. The camp is to start in a week's time. Which of the following patients would you choose for treatment in the camp?***

a) The patient said he could hear voices who talked to him on and off about what to do or not to do. Sometimes the voices commanded him not to eat and he skipped his meals.

b) The final selection of patients was nearly complete. They could take in only one more patient. The counsellor had to choose between the thirty five year old agriculture labourer and the forty year old lorry driver.

c) The patient was from a village about 40 kms. away from the camp site. "It takes only two hours to come here. I will come everyday for the family programme. It's no problem," assured the wife.

4) ***Read the following situations and comment on the appropriateness / inappropriateness of the treatment staff***

a) It was the first day of the treatment camp. The patients waited expectantly for the doctor and counsellors to arrive. The counsellor arrived perfectly dressed - wearing a thin nylon saree with high heal shoes, lip stick and eye shadow, everything perfectly matched. The patients looked at her in awe.

b) The treatment team wanted to employ a recovering addict as a counsellor. Tony was a 22 year old addict who was 6 months sober. He was enthusiastic and willing to work hard even without pay for he wanted to help other addicts.

c) The day's programme was to start at 9.00 a.m. 'It's almost 9, Can I ring the bell" asked a patient. "Let me finish my tea, you can ring the bell in about 15 minutes" said the counsellor.

One month Regional Training Programme on 'Prevention and Management of Addiction' from 19th November (Monday) to 13th December (Thursday) 2001
Sponsored By National Institute Of Social Defence, Ministry Of Social Justice & Empowerment, Government of India, New Delhi
Organised by T T Ranganathan Clinical Research Foundation, Chennai 600 020

TIME TABLE – FROM 19TH NOVEMBER TO 13TH DECEMBER 2001

Date	09.30 –11.15	11.30 – 1.00	2.00 – 3.15	3.30 – 4.45
19.11.2001 (Monday)	Introduction Welcome Address About the training programme (VT)	Sharing by participants – problem of addiction in their area, about the NGO, their experience in the field of addiction (VT)	Disease Concept of Addiction (SR)	Activity - case study (SR)
20.11.2001 (Tuesday)	Basic facts about alcohol (VT)	A day at TTK – Patients programme (RC)	Classification of drugs, short-term, long-term effects and withdrawal symptoms(Dr. AR)	Activity - quiz
21.11.2001 (Wednesday)	Building relationship (Rachel George)	Personality defects (R.C.)	Medical Complications related to addiction (Dr AR)	Psychiatric complications related to addiction (Dr.Suresh Kumar)
22.11.2001 (Thursday)	Motivation techniques (AJ)	Contd... Role play(AJ)	Denial (RC)	Loss and grief (SR)
23.11.2001 (Friday)	Counselling	Contd....(VT)	Anger and violence (Sudha)	Whole person recovery (AJ)
24.11.2001 (Saturday)	Art therapy (Kanakam)	Contd...	Spirituality and activity (SR)	Record Keeping (VT)

WEEK TWO

Date	09.30 –11.15	11.30 – 1.00	2.00 – 3.15	3.30 – 4.45
26.11.2001 (Monday)	Feelings of family members and stamp game (SHEEBA)	Guidelines and responses of family members (RN)	Co-dependency (Revathy Thomas)	Structuring family Programme (VT)
27.11.2001 (Tuesday)	Children of alcoholics (RJ)	Parenting skills	Contd... (Ambika Sen)	Problems in recovery (FJ)
28.11.2001 (Wednesday)	Marital counseling (Dr. Vijay Nagaswami)	Contd...	About HIV-AIDS (Dr. Anita Rao)	Harm Reduction Programme (Dr. Srivatsan)
29.11.2001 (Thursday)	Causative factors in addiction (Dr. Mohan Isaac	Impact of addiction (Dr. Mohan Isaac)	Pre and post test counseling (Dr. Shanthi Davidar)	Contd...
30.11.2001 (Friday)	Dynamics of relapse (RJ)	Dry drunk symptoms (A.J)	Methods to stay sober (FJ)	Client profiling (VT)
1.12.2001 (Saturday)	Group therapy (VT)	Contd....	Self-help group concept (Mr.K)	Sharing by AA / NA members

WEEK 3 (Field Placement)

TTK Hospital - 7 trainees

After Care Centre - 5 trainees

Rajaji De-addiction Centre - 5 trainees

DESH - 5 trainees

CHES - 5 trainees

WEEK 4

Date	09.30 – 11.15	11.30 – 1.00	2.00 – 3.15	3.30 – 4.45
10.12.2001 (Monday)	Presentation on the field placement (Dr.Cherian)	Contd...	Self-esteem (SM)	Criticism and activity (SM)
11.12.2001 (Tuesday)	What works in treatment (RC)	Activity	Community approach of treatment (Sudha)	Minimum standards of care (S.R.)
12.12.2001 (Wednesday)	Assessment (Kanakam)	Contd...	Visit to YRG Care	-----
13.12.2001 (Thursday)	Prevention programme – Industry and school programme (VT)	Contd...	Evaluation and valedictory	

Intake format

Name ~~Mr George~~ Age Date of intake :

Language of choice Marital Status Occupation

Accompanied by

Years of drinking / drug abuse:
Years of excessive drinking / drug abuse:
Present pattern of drinking/drug taking:

Presence of :

Use of other drugs	: Nil/past use only/presently using
Psychiatric problem	: Nil / Mild / Moderate
Denial	: Mild / Moderate / Severe

Physical problems(record specifically):

Prior treatment for addiction / other problems:

Willingness for treatment: Unwilling / half-hearted / willing
Motivating factor for present treatment effort :

Any issue / concerned expressed by client/family:

Impression of intake counsellor :

Action taken : Admitted / Given later date / referral / denied admission

Category of payment : TTR / B ward / A ward / Company

Address with contact phone number if possible

Signature of Counsellor

MH - 2c - 4

INTERNALISING TOOLS

QUIZ

1) Name the plant source of heroin. *bupprin*

2) What kind of addictive drug is present in cough syrups that are abused? *Coady*

3) To which category of drugs does buprenorphine belong? *Narcotic*

4) The addictive potential of heroin is low – True or False? *False*

5) What is the psycho-active chemical present in ganja? *delta hy*

6) What are the kinds of drugs that come under the category of Cannabis? *hanja, hash Bhang*

7) Smoking ganja is safe as it comes from a plant – True or False?

8) When is the effect of ganja stronger – when eaten or smoked?

9) To which category of drugs does LSD belong? *Hallucinogens*

10) Beer drinkers never become alcoholics – True or False?

11) What kind of drugs can cause synesthesia? *Hallucinogent*

12) If a drug abuser is eating a lot of sweets what kind of drug could we have taken? *hanja*

13) Which category of drugs can cause itchy skin? *herion*

14) What is "mainlining"? *injecting intravenous*

15) Which is the most commonly abused drug in India? *Alcohol*

16) What is the percentage of alcohol usually present in beer? *6 to 8%.*

17) What is the name of the chemical present in alcoholic beverages? *Cthyl*

18) What can cause sudden death due to sniffing? glue

19) Of which drug is constipation the well known side effect? Norcatic

20) What is the connection between a drug's short term effects and withdrawal symptoms? Just opposite

21) A person can drive safely immediately after drinking three pegs of whisky True or False?

22) Can pain killers become drugs of abuse? yes

23) If a person regularly takes vitamins and liver supplements, his liver will not be affected even if he drinks alcohol heavily – True or False?

24) Brown sugar reduces one's appetite – True or False? ✓

MH-2c.5

CASE ANALYSIS

Please point out what is inappropriate in the following examples:

Don't ask so many questions.

1) Counsellor: Come in. Sit down. Tell me your name. Where are you from? Are you married? Has somebody from your family come with you?

2) Client : All the years of married life I have been most unhappy. I hope this treatment will work.

   Counsellor: Don't worry. Everything will be alright. Just bring him here.

   ~~Don't give definite assurance~~ falsely assuring

   Don't give any assurance and give hope for it-

3) Counsellor: Your daughter-in-law told us that you are not willing to get your son treated for addiction. What is wrong with you?

   confidentiality broken

4) Counsellor: It is one month since you rejoined your husband. Are you happy? Close door question

   Client : Yes M'am

5. Client : Please advice my wife. She fights with me all the time. After a days of hard work, I cannot relax. Sometimes I feel I am going mad.

   Counsellor: How many years has it been since you got married?

6) Client : My father still treats me like a kid

   Counsellor: He is treating you just the way his father treated him. That's all.

   analatic solution

7) Client: I became terribly angry

   Counsellor: Come on! Don't tell me you were angry just for a 10 minute delay.

8) Client: I have been waiting for two hours to see you.

Counsellor: I can't help it. I was not sitting here simply.

9) Counsellor: This is the third time you have had a relapse. Why can't you understand? Can't you think properly?

10) Comment on the appropriateness of the responses listed under each statement.

Client: That's it, Madam. I have told you the entire story. Now, you tell me what I should do. Shall I leave my husband or continue to stay with him?

Counsellor:

a) You have been married for six years. Why don't you try and patch up the marriage?

b) Sounds like you have two kinds of feelings. There are a few reasons why you should leave and a few to continue in the marriage.

c) Your children will be affected. Children from broken families are. Shouldn't you think of them? Your parents also may not like it if you get separated from your husband.

11) Client: Taking medications regularly for a whole year is a big bore

Counsellor:

i) There is no short-cut to that
ii) Shall I take the medicines instead of you then?
iii) A year will go by quickly. Don't worry
iv) If you can't spend even 1 minute to take it - you are just lazy

MH-2c.6

CASE STUDY

Murugan is a 35 years old farmer. He is married and has two children. He leads a happy and contended life with his wife and children and lives within his earnings. The way Murugan was running his family was taken as an example for the entire village. Every Saturday, after receiving his weekly wages. Murugan would buy Halwa for his children and flowers for his wife. His wife too, would wait for him with his favourite dishes. On festival days and occasions, the entire family would go to a temple and enjoy themselves.

While leading such a happy life, one day one of Murugan's friends came to his house and enquired about Murugan's health and well-being. Murugan informed him that he was happy except that for the past two days he was having cold and fever. Immediately, his friend took out a bottle from his bag and asked Murugan to drink a little from it, promising that the relieved of his cold. Later, his wife enquired about the foul smell emanating from him. Only then did he realise that he had taken a drink similar to toddy.

After a few days, when Murugan was very tired – after a hard day in the fields – he wanted to drink and relieve his tiredness. So, he went to a nearby liquor shop and drank. As days passed, his drinking became a daily habit. He lost interest in eating and also playing with his children. He stopped giving money to his wife to run the family.

One day when Murugan returned home drunk, his wife was very angry and shouted at him. She accused him of not eating properly, not giving money regularly and asked him as to how she could run the household under such circumstances. Thereupon, Murugan too became angry and started shouting at her and in his anger, broke the water pot. Next day , he casually enquired about the disappearance of the water pot. Though Murugan could not remember anything of the incident, his wife was seething with anger.

While Murugan was working in the fields, his thoughts were totally centered around his drink. He was worried as he had no money to buy his next drink. He was wondering if he could sell the old radio set at home and drink with the money raised out of such sale. At this point of time, one of his friends came to him and commented that for the past few days, he appeared to be weak and unhealthy. Murugan, thereon, explained his condition to his friend stating that if he did not drink, he was not able to sleep well at night or eat proper food and that was the reason for his drinking.

Ten days later, when Murugan's wife asked for money to buy monthly ration, he did not have money. The same evening, he borrowed Rs.150/- from his friend, Kandhan. On his way back home, Murugan went to a liquor shop and got drunk. He also purchased three packets of biscuits half a kilo of Halwa and plenty of flowers for his wife. When he reached home and gave these to his wife, she was angry as there was not even a grain of rice at home.

In the meantime, Murugan's daughter was down with high temperature. They had to take her to a hospital. Murugan offered to bring an autorickshaw for this purpose and he went out. As he was worried and tense he thought of taking just a glass of liquor to relax and than take an auto home. But, when he started drinking, he could not stop with one and it went on and on. That night, he did not return home. The next day, he went home with a feeling of guilt and shame and promised that he would never drink again. The promise was for just one day. The next day he drank again.

Around this time, Murugan decided to go to Sabarimalai on a pilgrimage. As part of the rituals, he was required to abstain from drinking for a period of forty days. Accordingly, he abstained from consuming alcohol for the next forty days. On the forty first day, he started drinking and that too excessively. His wife and children were hurt and angry.

On seeing his condition, one of his friends – a well wisher asked him why he drank? Murugan told him that if he had a wife who could understand his problem, there would be no need for him to drink. He told another friend that if he could repay all his debts, he would be able to give up drinking totally.

However, Murugan continued drinking. He was now drinking in the mornings and as well as in the evenings. His health deteriorated rapidly.

But when he stopped drinking, the next day his limbs were shaking badly. With great difficulty, he abstained from drinking for the next two days. On the third day, he complained to his wife that he was hearing strange voices and that he was seeing some huge figures in front of him. His wife got the impression that he had got scared of some vision and gave him prasadam brought from the temple.

In the meantime, Murugan's landlord gave him Rs.400/- and asked him to buy fertilizer from the next village. When he went to buy the fertilizer, Murugan drank excessively from a liquor shop and became unaware of his surroundings. At this stage, someone robbed him of his money. When Murugan regained his senses and found that the money was missing, he did not know as to what to do. He returned home dejected. He wishes he were dead and shared this feeling with his wife.

She told him that a camp was being organised at the village for the treatment of alcoholics. The village officer had also wanted Murugan to avail this opportunity. Later, Murugan enrolled in the camp and got himself treated.

Identify the symptoms of addiction.

A CASE STUDY - Co-Dependency

When Uma and Ashok married, they were both healthy young people. They had college degrees, satisfying jobs, close relationships with friends and family members and enjoyable hobbies. After two years of marriage their first child was born and about that time Ashok also got a significant promotion in his job. He accepted the position of supervisor over a large region of his company. This promotion brought a considerable pay raise that enabled him to purchase a new home for their growing family The unpleasant side of the promotion was that it called for Ashok to travel out of town for several nights a month. During his travels away from home, Ashok started drinking and gradually switched over to brown sugar .

After seven years of marriage, his brown sugar use steadily increased, and he began to give up healthy involvement. He seldom visited his close relatives or played with his children. Uma and Ashok now had three young children, and Ashok frequently complained about the noise and normal clutter children create in the house. His life consisted of 'going off on business trips', spending long hours outside home when he was in town, shouting and sleeping. He showed little interest in the family and after seven years of marriage, Ashok had become a 'difficult' husband.

Because Ashok's addiction developed slowly, Uma did not recognize it for quite sometime. She rationalized that the longer periods he spent away from home were part of his job. But it bothered her that he had little time for family, friends and hobbies; but she figured that it was all a passing phase in their life together. One day, she reasoned, Ashok's work would let up and they could go back to being the happy couple they once were. Finally Uma knew he had a problem, but didn't know what to do. She asked him to stop many times, but each time this only started an argument that led to more problems

Realising that Ashok was pulling away from her and everything they had once held dear, Uma tried hard to make him happy and avoid making him mad. She cooked his favorite meals, kept the house clean, switched on the television for the' kids to watch so they would be quiet when he was home, and even submitted to more frequent sex with him. She also assumed responsibilities that had once been his like paying the bills, going to the bank, etc . Eventually, her life became focused on keeping Ashok happy so that he wouldn't use brown sugar.

Her efforts didn't work, and often he found something to complain about. And he didn't stop 'using'. In fact, his addiction increased. Uma became even more determined than ever to bring him back.

One day while shopping at the supermarket, Uma met her sister, Geetha who asked how she was doing. They were living in the same city , but had never met for quite a long time. Whenever Geetha said she would come home, Uma would give some excuse and prevent her from visiting her. Uma was not happy to have met her sister. She was afraid she might come to know about Ashok's problem. "How do I avoid her? How do I leave this place?"-She was so preoccupied that she didn't hear her sister who was enthusiastically talking to her. Uma quickly left that place to avoid further questioning by her sister and deluded herself that she had succeeded in hiding their family "secret" from the rest of the world. Geetha nodded sadly, seeing Uma not the person she had known earlier.

The fact is Uma's entire personality had changed overtime. She never took any interest in dressing up neatly or even combing her hair. She always had a worn out face. She stopped going to the temple because she was convinced that God had been unjust to her. She stopped lighting a lamp in the pooja room. She kept it dark as she believed that God had darkened her life.

That night when Ashok came home late as usual, Uma got wild and started shouting and arguing with him. He shouted back and both of them went to bed without taking dinner. She was unable to sleep and the next morning she got up with a severe headache. She could not prepare breakfast for the children and they had to go to school without taking proper food. When the children complained they were hungry, she shouted at them -" None of you notice how I am suffering. As it is, your father is giving me enough problems. Don't pester me with your minor issues"

After sometime Uma felt sorry for her children and decided that she would not shout at them any more. " If I don't cook for them, where will they go?. It is all because of this man! From now onwards I am going to be indifferent to him . Let him do whatever he wants to do. I will not shout. I'll not cry. I have had enough of it". She decided to remain calm but as soon as she saw him, she got irritated and started shouting. After quarrelling with him, she felt very depressed, run down and weak. She went to bed hardly remembering that children would come from school hungry and she had to keep something for them to eat.

What are the co dependency behaviour patterns you notice in Uma?

RELAPSE - CASE STUDY

Satish, 25 years old, was working in a departmental stores. He underwent treatment for ganja addiction and was responding well during the initial 2 months. He was regularly attending NA meetings. His elder brother, Mahesh was very caring and he would sit with Satish and talk to him in the evenings, drop him at the NA meeting place and pick him up.

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Satish went to the store in a bad mood. His table was filled with papers and was in a total mess. He could not find the file he was supposed to work on. He shouted at everyone. When his manager saw Satish, he warned him and insisted that he should complete the job before 4o'clock. Satish got wild and without thinking for a moment, submitted his resignation and left that place.

To him the whole world appeared unjust. "Why is everyone behaving like this? Nobody appreciates what I am doing." When he went home, his mother asked him," You have come home so early today. It's only 11 in the morning. Is the store closed today?" Satish would not answer her. He straightaway went to sleep When he got up in the evening, Mahesh approached him and wanted him to share his problems. But Satish did not want to tell him that he resigned his job. So he shouted at him also and straightaway went to see one of his old "friends"

a) What are the warning signs of relapse which you notice in Satish?

b) What are the positive reinforcers which can be strengthened towards achieving sobriety?

c) What are the warning sign management plans you would like Satish to make?

A CASE STUDY - Co-Dependency

When Uma and Ashok married, they were both healthy young people. They had college degrees, satisfying jobs, close relationships with friends and family members and enjoyable hobbies. After two years of marriage their first child was born and about that time Ashok also got a significant promotion in his job. He accepted the position of supervisor over a large region of his company. This promotion brought a considerable pay raise that enabled him to purchase a new home for their growing family The unpleasant side of the promotion was that it called for Ashok to travel out of town for several nights a month. During his travels away from home, Ashok started drinking and gradually switched over to brown sugar .

After seven years of marriage, his brown sugar use steadily increased, and he began to give up healthy involvement. He seldom visited his close relatives or played with his children. Uma and Ashok now had three young children, and Ashok frequently complained about the noise and normal clutter children create in the house. His life consisted of 'going off on business trips', spending long hours outside home when he was in town, shouting and sleeping. He showed little interest in the family and after seven years of marriage, Ashok had become a 'difficult' husband.

Because Ashok's addiction developed slowly, Uma did not recognize it for quite sometime. She rationalized that the longer periods he spent away from home were part of his job. But it bothered her that he had little time for family, friends and hobbies; but she figured that it was all a passing phase in their life together. One day, she reasoned, Ashok's work would let up and they could go back to being the happy couple they once were. Finally Uma knew he had a problem, but didn't know what to do. She asked him to stop many times, but each time this only started an argument that led to more problems

Realising that Ashok was pulling away from her and everything they had once held dear, Uma tried hard to make him happy and avoid making him mad. She cooked his favorite meals, kept the house clean, switched on the television for the' kids to watch so they would be quiet when he was home, and even submitted to more frequent sex with him. She also assumed responsibilities that had once been his like paying the bills, going to the bank, etc . Eventually, her life became focused on keeping Ashok happy so that he wouldn't use brown sugar.

Her efforts didn't work, and often he found something to complain about. And he didn't stop 'using'. In fact, his addiction increased. Uma became even more determined than ever to bring him back.

One day while shopping at the supermarket, Uma met her sister, Geetha who asked how she was doing. They were living in the same city , but had never met for quite a long time. Whenever Geetha said she would come home, Uma would give some excuse and prevent her from visiting her. Uma was not happy to have met her sister. She was afraid she might come to know about Ashok's problem. "How do I avoid her? How do I leave this place?"-She was so preoccupied that she didn't hear her sister who was enthusiastically talking to her. Uma quickly left that place to avoid further questioning by her sister and deluded herself that she had succeeded in hiding their family "secret" from the rest of the world. Geetha nodded sadly, seeing Uma not the person she had known earlier.

The fact is Uma's entire personality had changed overtime. She never took any interest in dressing up neatly or even combing her hair. She always had a worn out face. She stopped going to the temple because she was convinced that God had been unjust to her. She stopped lighting a lamp in the pooja room. She kept it dark as she believed that God had darkened her life.

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What are the co dependency behaviour patterns you notice in Uma?

CASE STUDY

Arun underwent treatment for his alcoholism. On the day of discharge, he told everyone he would come again to TTK Hospital only to celebrate his birthday and that he would definitely not relapse. The counsellor talked to him about the importance of follow-up, the need to take Esperal and attend AA meetings. Yet, Arun kept insisting that he did not really need these- `I am willing to take a bet that I will not relapse'.

Arun came for follow-up only because his wife and counsellor insisted. on it. After two months, during a follow-up visit, his wife, Usha complained that he was getting angry over minor issues. She was also upset about his impatience. He expected her to anticipate all his needs like fetching water to drink and fulfil them even if she was very busy in the kitchen. Arun brushed aside all these issues and said that she was exaggerating.

At home, Arun was spending many evenings alone in a room. He had very little to communicate to his family. He did not want to go out with them - to the temple or even to their cousin's wedding. He said, `It is too boring'. He kept on moaning `Why did these things happen to me? Nobody appreciates what I am doing'.

One area that Arun was very happy with was his job. He went to work regularly and felt good about the appreciation he received. Slowly, he started increasing the working hours and came home only at 8.00 p.m. When he reached home, he was too tired and could only eat and sleep The family members were unhappy with Arun for he rarely took them out or even speak to them. `It is better this way', he said.' I am bored at home. After all I am working only for all of you... Even when I am not drinking, you have something to complain about'.

He was unwilling to even take the child to the doctor or fetch an electrician when repair was needed. When Usha requested him, he told her `I cannot do everything - you run the house'. Whenever the issue of taking responsibilities at home came up, an argument would erupt, Arun would threaten to drink and his wife would give in.

Gradually, even taking Esperal became an issue. He would take it if he was in a good mood. If not, he would brush it aside and walk away just to scare his wife. Later, Usha noticed that he was again in touch with his drinking friends. When asked, he said, `I am not sitting with them'. I am just talking over the phone. What harm can this cause? You simply want me to do whatever you tell me to. I won't drink, I know it.'

not regular

A month later, Arun came home under the influence of alcohol.

what are the dry drunk symptoms?

RELAPSE - CASE STUDY

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MH-2c.6

CASE STUDY

Senthil, 18 years old, is studying in a technical education institute. His father is working in a factory as a supervisor. His father takes alcohol on and off.

Senthil learnt to use brown sugar from his fellow friends at the institute. Now he takes drugs regularly.

One day, Senthil was smoking Ganja on the terrace. The mother was shocked to see him smoking. But she pacified herself, "he is only smoking cigarettes. He is not drinking like his father. He must have learnt to smoke from his friends. I should not make an issue of this. I should not tell his father." She called Senthil and advised him to give up smoking as it causes many illnesses.

Self-denial

As days went by, there were a few more changes in Senthil. Half the time he would not eat, saying that he was not hungry. Then, Senthil's mother would make curd rice, and force him to take food.

One day, there was a letter from his institute stating that he had not paid his fees. His mother had already given money to Senthil to pay his fees. On seeing this letter she was shocked. She pawned her ear rings and paid Senthil's fees. She apologized on behalf of her son to the authorities, saying, "I forgot to give him money for fees". On reaching home, she shouted at Senthil. He said someone had stolen the money from his purse and he was afraid to inform her. Hence he had not paid the fees. The mother felt that he might be lying. Somehow she wanted to believe that he was telling the truth.

One day, in the market place, Senthil's mother met one of his friends. He told her "Senthil spends a lot of time with drug addicts. He is irregular for classes. He has not written his final exam." Senthil's mother felt very upset. On going home, she searched his cupboard. She found cigarettes, match boxes and small packets. She collected all of them and threw them in the dust bin. When Senthil entered home, she shouted at him and made him promise in front of God that he would not touch drugs in future. After that Senthil looked alright for a few days and his mother was not sure whether he was taking drugs or not.

One day, Senthil's father received a phone call from the police station. The policeman said that Senthil had brown sugar in his possession and was, therefore kept in the police station. On hearing this, Senthil's father paid money for providing bail and brought him home. Senthil's mother blamed his father for the problem of his son. But the father blamed the mother that she was not capable of bringing up the children. On bringing back Senthil from the police station, they found him with running nose and watery eyes. Senthil was taken to a treatment centre by his parents.

What "enabling behaviour" of the mother do you notice in this case study?

MH- 2c.7

DEALING WITH DENIAL

Denial is a psychological process that takes place at the unconcious level in an addict. Denial is a core component of the disease and it gets strengthened as addiction progresses. During the process, the addict's mind recreates an illusion so convincingly that he believes it to be the `reality'.

Why does the addict deny his problems?

Normally, no one wants to be categorised and stigmatised as a weak willed person, morally and mentally inferior to others and subject himself to punishment, disapproval, rejection and social boycott.

- The moral stigma and legal barrier associated with addiction, provides the ground for denial
- The enabling behaviour of the people around the addict promotes denial.
- The addict's tendency to avoid internal comflicts encourages denial.

As a person's addiction progresses, conflicts are created. On the one hand, the drug becomes a very important component of his life - because it produces in him a sense of well-being and helps him to forget problems. On the other, reality tries to reinforce the awareness in him that drug use only leads to unmanageable problems. At this stage, he has two options open to him, reject addiction or reject reality. He takes the easy route of rejecting reality and the process of denial continues.

There are several types of denial observed amongst the addicts:

SIMPLE DENIAL: Initially, the addict totally denies the existence of the problem of chemical dependency, even though the problem is quite obvious to others around him. For example, the addict may say `I smoke only occasionally'.

MINIMISING: The addict underplays the extent of the problem. Here, though he would superficially agree that he has a problem (with drugs) he would minimize the extent of damage. "I give enough money to my wife to run the family and there are no financial problems as it is made to appear".

BLAMING OR PROJECTING: He starts blaming others for his drug use. He holds them responsible for his own short-comings. For example, he blames his parents `for not caring for him, having no feelings for him, always nagging him' and that he uses drugs only to forget his worries.

RATIONALISING / GIVING EXCUSES: The addict does not admit that the real problem is his addiction, but goes on giving innumerable excuses, justifications and alibis for his behaviour. For example, `I take drugs because it increases my creativity'.

INTELLECTUALISATION: Here, the addict avoids facing addiction related problems by dealing with them at a superficial, general, theoretical and intellectual level. For instance, he says that he knows the damage that addiction would cause and he is not so stupid as to allow it to cross the limit.

DIVERTING: At this stage, the addict changes the topic of conversation whenever it focuses on drug-use or related problems. For example, whenever a well-wisher points out to him the severe problems faced by him due to excessive drug-use and suggests approaching a doctor for treatment, he would not allow him to continue, but would deliberately interrupt and totally divert. He would also ensure that the topic of his drug-use does not come up again.

HOSTILITY: He prevents others broaching the topic of his addiction by getting angry and aggressive or he avoids it by leaving the place.

SILENCE: Sometimes, the addict deliberately chooses to maintain silence, whatever be the provocation. He resorts to this method in order to withdraw from reality.

The process of denial goes through 3 stages

1. During the First Phase, the addict thinks that he is in total control of himself and feels independent. Normally he is not prepared to listen to others in the matter related to addiction. During this phase, his family also minimizes the extent of the problem. For example, the wife says, "He gives me money to run the family. The problem is after all not that acute". This sets the stage for his denial.

2. During the Middle Phase, as addiction progresses, he is no longer able to function independently. Others around him try to hide the problem in an attempt to protect the dignity of the family. They pay back his debts, feed him when he comes home under the influence of drugs. His friends at the office also protect him by taking over his responsibilities. Such enabling behaviour of others around him encourages his denial.

3. During the Chronic stage, addiction has progressed to such an extent that others around him are not able to manage the problems created by his abuse. They stop covering up. He is unable to handle the situation and faces some crisis or the other.

What is enabling behaviour?

"Enabling" is a therapeutic term which denotes a destructive form of helping. Any act that helps the addict to continue taking drugs without suffering the consequences of his inappropriate use of drugs is considered "Enabling Behaviour".

The Enabler

The Enabler is a person who may be impelled by his own anxiety and shame to rescue the addict from his problems. He wants to save him 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 addict what the person really thinks, "You cannot face your problems without me". Thus, in reality, the "Enabler" is meeting a need of his own, rather than that of the addict, although he does not realize it himself. The enabler actually reveals a lack of faith in the addict's ability to take care of himself.

This role is normally played by colleagues and friends. The behaviour of these people conditions the addict 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 addict knows that they always will. Such rescue operations are as compulsive to them as drug taking is to the addict.

Victim

The victim is usually the employer, the supervisor or a co-worker. When the addict fails to perform his job, the "victim" normally completes the work. If the addict is absent due to taking drugs, the "victim" gets the work done for him.

By the time drugs start interfering with a man's job, he may have been working for the same company for quite a number of years, and his supervisor or employer, by now would have become his close 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 addict again and again. He becomes completely dependent on this repeated protection and cover-up by the victim.

In short, it is this "victim" who unknowingly helps the addict to continue with irresponsible drug use without losing his job.

The Compensator

The key person is normally the wife or parents of the addict. This person has played the role of "compensator" much longer than anybody else. She has to take up the responsibility to hold the family together in spite of all the problems created by his addiction. She controls, sacrifices, adjusts but never gives up.

In helping the addict, she unconsciously meets a need of her own. She builds her self-worth on the addict's total dependence on her and continues to protect him from every crisis.

When he gets into trouble, her typical response is to minimize 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 the ways the compensator minimizes 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. Every time they try to rescue an addict, they are only postponing the necessary treatment.

He will recover only if the above mentioned people learn to break his dependency on them and make him see the problem which has led to the crisis situation. He will then find it impossible to deny the problems associated with his use of drugs and it is the crisis that will force him to come for help in despair.

The Enablers, the Victims and the Compensators, too, must change their roles, so that the addict's denial is broken and he realizes the need to take help.

They should realize that:

- Denial is the result of the social stigma attached to addiction; the addict's defence mechanism and the `enabling behaviour' of the people significant to him encourage denial.
- A crisis is an opportunity to break the denial - it need not be threatening. Out of the crisis, opportunities for intervention develop.
- 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 Role of the Counsellor

- Initially, the goal of the counsellor should be to establish an empathetic relationship with the addict. Here, the counsellor shall maintain a supportive, non-threatening climate. The counsellor's emphasis shall also be on the need of the addict to seek treatment. This would, in turn, generate a feeling in the addict that he is accepted as he is.
- Once, in treatment, the counsellor should assess the extent of denial and also the magnitude of the problems caused by it. The addict should be exposed to re-educative lectures, group therapy sessions and individual counselling. As a consequence of this process, the denial will start breaking down on its own.

- The counsellor should help the addict realize the magnitude of his problem and make him accept the need to bring about the required changes. If still denial is not broken, confrontation is a technique which can be used.

`Confrontation is the deliberate use of a question or a statement by the counsellor to induce the patient to face what the counsellor thinks the patient is avoiding'.

The counsellor goes in for confrontation after:

a) Establishing mutual trust.
b) Showing empathy.
C) Collecting factual information.
d) Identifying the various discrepancies in the statement made by the addict.
e) Preparing the family members, if they are to be involved in the process.
f) Providing focus on the need to change.

However, during the process of confrontation, the counsellor should not moralize, condemn or provide solutions. Confrontation could be carried out during individual counselling sessions, group therapy sessions and individual sessions with the medical practitioner.

Confrontation may have the following outcome and the counsellor respond appropriately.

Outcome	Counsellor's Response
Patient may accept confrontation	Reinforce positively
Defy confrontation	Maintain empathetic response
Act confused Ambivalent	Focus on current feelings and later deal with issues again
Break the relationship	Assure him that help is available and provide support to family members.

To conclude, dealing with denial is the most crucial step in rehabilitation, for unless denial is broken, the chemical dependent will not be motivated to become actively involved in the recovery effort. By effectively breaking his denial system, however, the professional can help him not only to deal with his problem with drugs, but also to deal with other life areas.

MH - 2c. 8

ASSESSMENT

Assessment concerns

- Identifying the nature of problem
- Severity of problem behaviour
- Understanding conditions that have caused
- Conditions maintaining the problem behaviour

Assessment helps in

- making decision concerning hospitalization
- prescribing medications
- role of psychotherapy
- the modification of family patterns
- related aspects of treatment

Nature and comprehensiveness of clinical assessment varies from setting to setting

MEDICAL EVALUATION

Data of patient's general physical state and any physical pathology that may have a bearing on his problem behaviour

- Headache
- Seizures

PSYCHOLOGICAL ASSESSMENT

Interviewing

Face to face conversation between two people to obtain information on various aspects of life situation

- simple intake interview
- structured M.S.E

Psychological tests

Specialized assessment procedures

- The intelligence test
- Rorschach ink blot tests
- The thematic apperception test

Direct observation of behaviour

Usually confined to hospital settings - helps to learn about patient's psychological make up and level of functioning

- Delirium tremens

Assessment of groups

- Focus is on the group as a social system
- Use of interviewing, psychological tests, observing patients
- Concerns determining social roles, communication patterns, aspects of group's structure and functioning

Integration of assessment data

- Helps to see if findings complement each other and whether definitive clinical picture is emerging
- If gaps / discrepancies are present, further investigation is needed
- Leads to an agreement on a tentative diagnosis based on which therapeutic goals are planned

PROBLEMS ISSUES IN ASSESSMENT

Confidentiality and informed consent

There is implicit or explicit agreement of the professional counselor to keep the information confidential
The loss of confidentiality seriously endangers the very relationship with the counselor
At times, information need to be shared with families, friends, relatives or other personnel for planning the treatment

- Special circumstances that warrant disclosure of information
- Harm to self or others
- Legal authorities require information

CULTURAL BIAS

- Tests are designed by the western psychologists and standardized based on studies conducted in their own countries
- Handicap for persons from other backgrounds in taking the tests. Scores may not be a fair measure of their potential
- Using culture specific tests and tests that are standardized in Indian population help

LABELLING

- Creates social stigma
- May brand a person and limits the opportunities open to him
- counselor needs to be sensitive on these issues, understand the impact of testing upon the patient and use tests with utmost discretion

THE MENTAL STATUS EXAMINATION

Purpose

- To evaluate quantitatively and qualitatively, a range of mental functions and behaviors at a specific point in time

- It provides important information for diagnosis, assessing the course of the disorder and response to treatment. It is important for psychiatric and neurological examination. MSE begins when the counselor first meets the patient

- Information and observation noted throughout the interview become part of the Mental Status Examination - patient's behaviors, thinking and mood
- At an appropriate point in time formal Mental Status Examination is under taken
- Earlier informal observations about mental state are woven together with the formal MSE
- The Mental Status Examination must be interpreted along with the presenting history and if necessary with further psychological testing, physical examination and laboratory studies
- Collateral information from families and friends are also valuable to confirm the diagnosis

KEY FACTORS TO BE CONSIDERED ALONG WITH THE MENTAL STATUS EXAMINATION

- It is important to have some understanding of patient's social, cultural and educational background. It helps the counselor to understand the subtle fluctuations in patient's mood and other details during MSE
- Patient's familiarity with the language used by counselor for mental status examination and age of patient are significant factors
- Patient may have difficulty in understanding various components of MSE, such as proverbs (used for assessing thinking process), if he does not know the language

MAJOR COMPONENTS OF MENTAL STATUS EXAMINATION

Appearance	Age, Sex, race, body build, posture, eye contact, dress, grooming, manner, attentiveness to examiner, distinguishing features, prominent physical abnormalities, emotional facial expression, alertness
Motor	Retardation, agitation, abnormal movements, gait, catatonia
Speech	Rate, Rhythm, volume, amount, articulation, spontaneity
Affect	Stability, range, appropriateness, intensity, affect, mood
Thought-Content	Suicidal ideation, death wishes, homicidal ideation, depressive cognitions, obsessions, ruminations, phobias, ideas of reference, paranoid ideation, magical ideation, delusions, over valued ideas
Thought process	Associations, coherence, logic, stream, clang associations, perseveration, neologism, blocking, attention
Perception	Hallucinations, illusions, depersonalization, derealization, Deja vu, jamais vu
Intellect	Global assessment: average, above average, below average
Insight	Awareness of illness

MAJOR LIMITATIONS OF MENTAL STATUS EXAMINATION

- Subject to interpretative bias
- Depends on the skill and experience of the counselor
- Without collateral information and other necessary investigations, reliance on MSE alone can lead to erroneous conclusions

GLOSSORY

Anxiety : Generalised feelings of fear and apprehension
Aphasia : Inability to communicate by speech, writing or symbols
Apraxia : Inability to complete purposeful movements
Catatonia : Form of schizophrenia marked by periods of rigidity, excitement and stupor.
Clang association : Speech in which words are repeated based on similarity of sound without regard to meaning.
Deja vu : Sense that one is seeing or experiencing something that has been seen before.
Delusion : A false belief, firm belief opposed to reality but maintained in spite of strong evidence to the contrary.
Depersonalisation : Loss of sense of personal identity, often with a feeling Of being something or someone else.
Depressed Cognitions : Depressive thoughts, of dejection, gloomy ruminations, feelings of worthlessness, loss of hope and apprehension.
Dysarthria : Difficulty in speech production.

Echolalia	: Imitative repetition of speech of another person.
Flight of ideas	: Rapid shifting from one topic to another, often with a common theme.
Hallucination	: Sense perception for which there is no appropriate external stimulus.
Homicidal ideation	: Thoughts of killing others.
Ideas of reference	: Ideas/beliefs of an individual that other people are talking about him, portraying his life on television or otherwise making reference to him in their activities.
Illusion	: Misinterpretation of sensory data, false perception.
Loosening of association	: Disturbance of associations that render speech vague and unfocussed.
Neologism	: Creation of new words; often a mixture of other words.
Obsessions	: Persistent idea or thought which the individual recognizes as irrational but cannot get rid of.
Paranoid ideation	: Presence of delusions of persecution/grandiosity presence of behaviours characterized by suspiciousness, envy, extreme jealously and stubbornness
Perseveration	: Excessive continuation of a response or action, usually verbal.
Phobia	: Irrational fear; the individual may realise its irrationality but nevertheless be unable to dispel it.
Schizophrenia	: Psychosis characterised by breakdown of integrated personality functioning, withdrawal from reality, emotional blunting and distortion, and disturbances in thought and behaviour.
Thought insertion	: A delusion that thoughts are placed in one's mind by an outside source.

MULTI PHASIC QUESTIONNAIRE (MPQ)

This questionnaire was developed by Dr.Vinodha Moorthy of NIMHANS from the Minnesota Multiphasic Questionnaire (MMPI), considered to be the mother of all inventories. It has been adapted to Indian standards and was standardised on Indian population. The test consits of following scales: anxiety, depression, mania, paranoia, schizophrenia, psychopathic deviation, hysteria and K-scale. These scales provide a clinically useful tool in determining the nature of condition on each of the clinically identifiable syndrome for the patient who is examined. The K Scale had been specially built into the test to check the susceptibility to lying or the tendency to unconscious self-deception. K Scale score beyond the cut off means "glossing over" or tendency to "Fake good".

WHAT EACH SCALE MEANS :

ANXIETY

- Free floating
- Inability to concentrate
- Difficulty in making decisions
- Extreme sensitivity
- Discouragement
- Sleep disturbances
- Excessive sweating / palpitations / tremors
- Sustained muscle tension

DEPRESSION

- Gloomy out look
- Loss of hope
- Social withdrawal
- Marked irritability
- Disinterest
- Slowing of thought process
- Obsessional worrying
- Exaggeration of problems
- Indecisiveness
- Negative self image
- Tendency to blame self
- Decreased motor activity
- Fatigue
- Insomnia
- Loss of appetite
- Decreased sex drive

MANIA

- Euphoria
- Elated mood
- Sociability
- Extreme impatience with restraint or criticism
- Short attention span
- Racing of thoughts
- Flight of ideas
- Impulsiveness
- Over talkativeness
- Orientation towards action
- Positive self image
- Tendency to blame to others
- Grandiose delusions
- Hyper activity
- Indefatigability
- Decreased need for sleep
- Variable appetite
- Increased sex drive

PARANOIA

- Absurd, illogical and changeable paranoid delusions, frequently of persecutory type
- Sometimes accompanied by hallucinations
- Suspiciousness
- Severe personality disorganization as in schizophrenia may not be present

SCHIZO PHRENIA

- Restricted affect
- Poor insight
- Delusions
- Hallucinations
- Sleep disturbances
- Disorganisation of thought and emotion
- Anxiety and panic
- Frequent loss of orientation to time, place, person
- Withdrawl from reality

PSYCHOPATHIC DEVIATION

- lack of guilt or remorse
- inadequate conscience development
- Irresponsible and impulsive behaviour
- Low frustration tolerance
- Rejection of authority / non confirming
- Inability to gain from experience
- Inability to maintain good relationship
- Ability to put up a good front to impress others and exploit others
- Manipulative

HYSTERIA

- Conversion reaction
- High suggestibility
- Dramatic
- Excitable but shallow emotional responsiveness
- Attention seeking

SCALE

- Faking good
- Glossing over

MPQ is usually given when:

- Patient does not "settle down" in the programme.
- He presents abnormal/bizarre behaviour.
- Understanding of issues in deaddiction is poor (reasons other than cognitive deficit.

Simple and clear instructions are provided for the patient on the top of the questionnaire. He is asked to circle "true" or "false" found against each statement on the sheet. It is important to establish rapport with the patient before the test (if it happens to be the first session). The patient should be asked to respond to all items without omitting any. If specific questions arise about the items of the questionnaire, the counsellor should respond in a non-committal manner. This test can be both self-administered and also by the counselor.

SCORING

The Scoring is done with the help of the scoring key. Under each scale certain items are listed against "True" and certain items against "False". If the patient had answered "True" for a "True Item" of the particular scale, 1 point is awarded and O point for vice versa. The same method is followed for "False" items also. The total score of " true and false" items of the particular scale are added and recorded in a table against the cut off scores of the respective scales. After scoring all the scales, evaluation is done.

INTERPRETATION

If the scores fall above the cut off, the particular scale is considered significant. Significance of the particular scale means presence of such a condition in the patient. Scores below the cut off is considered as insignificant.

COGNITIVE CAPACITY SCREENING EXAMINATION (CCSE)

This test is used as a shortened form of MSE to detect cognitive impairment. It measures orientation, calculation, attention, serial subtraction, immediate recall, memory and similarities. This test is less sensitive to delirium or dementia in elderly.
Cognitive Capacity Screening Examination is usually given when:

- Patients are screened for selection and camps deaddiction programme.
- Patients are screened for selection to vocational rehabilitation programme.
- Patients manifest poor understanding of issues during the deaddiction programme.

ADMINISTRATION

The patient is instructed to listen carefully and answer the questions. Counsellor calls out each question and records the answers given by patient discretely on the sheet. This test is administered by the counselor only and can not be self administered.

SCORING

One point is given for each right answer. Wrong answers are scored zero. The total number of correct responses is the patient's score for the test. The maximum possible score on this test is 30.

INTERPRETATION

A high score (above 22) means above average cognitive understanding. Low score reveals poor cognitive understanding. Low score are possible with cognitive or when patient is under influence or during withdrawals (due to lack of concentration and attention).

MH-2c.9

'WHAT WORKS' - OUR EXPERIENCE IN THE LAST 20 YEARS

Dr. R R Cherian, Director
Research & Treatment Services

PRIOR TO TREATMENT - WHAT WORKS

- Use Recovering patients (sobriety for a minimum period of 2-3 years) as valuable resources to motivate and offer help to new patients.
- Screen for psychiatric /medical complications and deal with them appropriately.
- Spend time with the patient and family to
  - make them understand the need for professional help
  - prepare them to go through the process of treatment
  - create hope and confidence
  - ensure that their expectation of the outcome is realistic.
- Select treatment agency according to patient's individual needs.
- Identify an agency which has a good image in the community. Ensure professionals in the agency having thorough knowledge about addiction and related issues.

DURING TREATMENT - WHAT WORKS

FOUR ESSENTIAL COMPONENTS OF PRIMARY TREATMENT

- Medical management
- Structured psychological therapy
- built in programme to involve family
- scheduled follow-up for a minimum period of 2 years.

GOAL CLARITY

- focus on 'whole person' recovery - drug free, crime free, gainfully employed and good relationship with family members.

TREATMENT PROCESS WHICH FACILITATES RECOVERY

- Providing opportunities for fellowship and interaction among patients.
- Giving importance to both group therapy and individual counselling. Using confrontation method to break denial.
- Providing accurate information about the illness, relapse process and recovery.
- Initiating patients into recreational activities and help them to enjoy.
- Helping the patients to forsee stressful events, high risk situations and develop coping skills to deal with them.
- Introducing AA steps and the concept of AA sponsorship - if possible work upto 4th step.
- Ensuring use of disulfiram for a period of 12 months.
- Ensuring support from family members and involving other significant persons from the community or from the industry.
- Helping the patient to strengthen his self-esteem - If he feels valued, accepted and respected, his motivation will increase.
- Giving special focus to clients with family history of addiction, early onset of addiction, disruptive social consequences and anti-social personality. Ensuring additional efforts in counselling

AFTER TREATMENT - WHAT WORKS AND ADDS VALUE

- After care issues to be specific and clear - Abstinence and improvements in every area of his life.
- Ensure regular follow-up visits as for other chronic medical problems.

  1 year 2 fold
  2 years 5 fold
  5 years 24 fold - recovery rate

- Letters, telephone calls and home visits, to meet this need.
- Ensure positive support from and understanding of colleagues and supervisors in industries.

- Work ethics to be taught - regularity in job, punctuality, discipline and improved interpersonal relationships.

- Ensure that the attitude towards the treatment agency is positive and the staff are seen as role models.

- Assess improvements periodically. Collect collateral information regarding the progress from family members / colleagues from workplace.

- Encourage the celebration of birthdays at the centre

- Handle relapses immediately so that the vicious cycle is broken.

- In case of patient with repeated relapses, look for alternative source of help - extended care, therapeutic community.

OTHER FACTORS

- The treatment centre to be airy, bright and comfortable

- Attitude of staff should be one of care. Staff to work as a team with understanding and clarity of roles.

- periodic staff development programme to update the knowledge and skills of professionals.

- Ensure methods to retain staff and to minimise turnover

- Information about patients to be documented in a computer for easy retrieval.

- Confidentiality about patients to be maintained

MH-2610

THE PROCESS OF ADDICTION COUNSELLING

Addiction for obvious reasons has been termed a baffling illness. Helping the addict overcome this illness, calls for an appropriately planned and skillfully managed counselling process. In addiction treatment, counselling essentially offers personal support and guidance to work towards the goal of abstinence from all mood-changing chemicals and also achieve qualitative life style changes.

The process revolves primarily around the relationship between the counsellor and the client. It is this relationship that leads to growth and change. The counsellor works "with" the client in and a sense of partnership, and collaboration prevails. The counsellor functions essentially as an ally or guide who helps the client change self rather than an expert who "fixes" everything the client needs.

The primary goal is to assist the addict in achieving and maintaining abstinence from addictive chemicals and behaviours. The secondary goal is to help the client recover from the damage the addiction has caused in his life. That is, the patient is encouraged to achieve and maintain abstinence and then to develop the necessary psychosocial skills to continue in recovery as a life long process.

The process of counselling moves through 6 stages from initiation of the counselling relationship to its termination.

Stage 1 - Developing a therapeutic relationship with the client

The success of any treatment effort, irrespective of the treatment model followed essentially depends on developing a deeply meaningful relationship with the client.

Being able to empathise with the client and perceive his life situation from his angle without being judgemental is extremely crucial. Demonstrating care and concern for the client and treating him as a human being worthy of respect helps strengthen the counsellor - client relationship. It is on the basis of this relationship that any further progress is made and nothing can be achieved without this.

Due to the nature of the illness, one is more likely to encounter a resistant, or even a hostile client who is grappling with a low self-esteem, low frustration tolerance and confusion about where he is and where he wants to go. Working with this client calls for a lot of patience and tolerance.

The first one or two sessions are usually spent on collecting information and session progresses depending on the pace set by the client. Asking too many question too soon can be threatening to the client and it is important to be sensitive to this.

It is a good practice to use the first session to explain the agency's programs, treatment goals and how individual counselling sessions will help. The client can be encouraged to express concerns about the treatment. Doubts may need to be clarified and fear set to rest and his motivation and involvement in treatment heightened.

The client usually uses the first few sessions to size up the counsellor, "Can she really understand me? How can I tell this stranger all about myself. What if she does not approve of me?" - are a few unsaid questions that he may bring with him. By being a good listener and by offering support appropriately the counsellor is gradually accepted by the client as a knowledgeable yet caring and non-critical individual.

The client usually discusses non-threatening and non-controversial issues first. He will probably be willing to talk about his job, family members, childhood etc. He will provide a lot of facts but desist from discussing the emotional issues involved. He may slowly progress and discuss his drinking / drug taking in a superficial manner.

Yet all the while, he is alert to non-verbal and verbal cues from the counsellor. When the counsellor is perceived as a trustworthy, caring individual the client will discuss more and more personal and sensitive issues.

By the end of the first stage, the client feels accepted and comfortable and is willing to reveal more about himself.

Stage 2 - Exploring problem areas

Addiction affects almost all the life areas – health, education / occupation, financial status, family relationships. Yet, the addict can be surprisingly ignorant of these issues. He refrains from self contemplation as it can trigger a lot of unpleasant feelings.

During counselling sessions, the client is gradually led into discussing each of these areas. Details about these areas and the impact of drugs on them have to be focussed. What, when, where, with whom, how long as well as how intense the problem is are questions that need to be dealt with. Certainly the picture that emerges will be complicated, for if it were not, the client would have coped with it long ago.

Talking about these issues in a "safe" environment is often cathartic to the client who finds relief in it. By getting the counsellor to understand him, the client understands his own problem in a clearer manner. The more he discusses his life situations, the clearer the perception becomes – both to the client as well as to the counsellor. At times, it will be helpful to get the permission of the client to talk to significant people in his life to explore problem areas. This would give the counsellor greater clarity about the areas she has to work on.

The counsellor in addition to being an empathetic listener needs to make use of her skills at this stage.

- The counsellor needs to be sensitive not just to the thoughts that are expressed but also to those that are not expressed, help the client focus on them and draw him out. Probing statements may need to be made to help him express himself more clearly. These statements / questions can move the therapy process to a meaningful state.

  "You discussed a lot about your father but I noticed that you rarely mentioned your mother's reactions. Can we discuss about it ?"

- Discussions need to help him express his feelings and not just facts. What are his feelings about the situations and how they are affecting him need to be clarified. Helping the client get in touch with his feelings is an important part of his recovery that helps him understand himself.

  Talking about his debts may provide details about his financial status. But helping him express his fears, frustrations, sense of loss as well as his hopes and aspirations take the counselling process to a deeper and more meaningful level.

- Talking about the past, revisiting particular events like marriage, child rearing, illness, conflicts with parents unleash a lot of feelings. The counsellor needs to be able to stay with the client in this process and deal with it rather than just reopen the past, listen to it and leave it in the open.

- Confrontation is a technique that needs to be used sparingly, judiciously and carefully. Confrontation needs to be made in a caring manner when there is a discrepancy between what the client says and the counsellor perceives or when there is a difference between what he said earlier and actually says now.

"You perceive your parents of not being supportive. Yet, they have funded your education and even your training course which you discontinued thrice. They have taken you for treatment and I can see that they visit you daily. Your mother is close to tears whenever she speaks of you. There seems to be a difference between how you see it and what is actually happening."

- Denial is a part of the disease of addiction. Justification, rationalisation and blaming are all part of denial. As therapy progresses, denial is slowly resolved easily in some areas and with resistance in the others. Flexibility to progress with the client is important. Counsellors need to work with the less problematic areas first before starting to work on the others.

- Client may discuss problem areas with clarity but may not link them directly / indirectly to the problem of addiction. The counsellor's role lies in helping him establish these links and see the whole picture rather than view it as fragmental issues. His psychological problems, poor job performance, social isolation – he may not see the picture as a whole and understand that addiction has contributed to the deterioration in a big way.

  " You said you had beaten your wife under the influence on alcohol. You failed to offer support to your wife when your child was seriously ill. For the past few months, you had not given money for running the household. Is there a possibility that the separation of your wife could have been the result of these incidents?"

- Involving family members in this stage is important. Family members are less confused and can provide details with more clarity. Moreover, just knowing that his family is also actively participating in treatment will keep his denial level low.

- Involving close friends or relatives as part of therapy is often beneficial.

By the second stage, the tendency to blame others for his problems is minimised and the client is helped to see it as "his problem". Only when this shift is made, meaningful problem solving is possible.

By the end of the second stage, the patient has a fairly realistic assessment of his problem areas. He accepts addiction as "his" problem and is motivated to work on it.

Stage 3 - Goal Setting

Clients often repeat generalised statements like, "I'll fix everything. I'll sort it out. I am going to be drug free and everything will be alright". Soon after they experience relief from the withdrawals and experience a sense of well being, many clients are over optimistic and see the future as a bed of roses.

To some other clients, life seems bleak and giving up drugs can make life seem more complicated.

No matter what his expectation of the future, goal setting is the next logical step in the sequence of events.

- Goals, need to be specific, realistic and appropriate. For eg. just saying "I'll pay back the loans" will not work. The client needs to work out a budget based on his present income, estimated expenditure and amount available to pay back the loans. Which debtor he will pay first, how much and when, are details that need to be worked out. Impulsiveness, grandiosity and indiscipline are traits that can make this part difficult.

- Setting goals gives clients a clear sense of purpose and instills a sense of drive and enthusiasm about the future. Goals also help evaluate one's progress or lack of it.

- Most of the issues are interrelated and some are more pressing than the others. Plans need to be made for each area – health, family, finances, use of leisure time, work as well as faith in a higher power.

Plans to maintain abstinence are often the priority. The main issues that need to be covered include

- Having a routine
- Identifying high risk places, situations and people where relapse is a possibility
- Coping strategies to deal with each of them.
- Methods to handle craving
- Need for continued support from counsellor and self help groups

- The counsellor as well as the client are active participants in the process. The counsellor may need to summarise or highlight issues discussed earlier.

"When discussing the past, we saw that there were short periods in which you pursued difficult goals vigorously, after a while just lost steam and let them die down. Right now you are full of plans of what you will do. You are planning to work full time as well as do an evening course. I am worried that you will repeat the same process again. I would rather that you start off with small manageable activities only and let the other issues wait till your sobriety is established".

- Establishing a few short term and long term goals is important. While going to work regularly may be part of short-term goals, getting a promotion may be the long term goal.

- The counsellor needs to brainstorm with the client about all possible options. Discussions about his future career may include being a sales man, a small time businessman, teacher or even a computer professional. Evaluating the different options and weighing the pros and cons is done primarily by the client with active prodding and stimulating statements made by the counsellor.

For example the patient who is contemplating a shift in his job may need to consider the work environment, familiarity with the job, the challenges involved, drinking and drug use in the work environment and not just the increase in the salary.

It must be remembered that the client is the expert about his recovery. It is his plan for his future rather than the counsellor's. Objectivity, experience and knowledge are the counsellor's strengths that are offered to assist him in his effort but it ends there.

Exercises of these sorts help develop problem solving skills in the client. Thus slowly he moves through the processes of effective decision making and learns self-reliance.

Stage 4 : Maintaining Change

The initial period of abstinence is usually euphoric. Plans that are made in the safety of the centre may not be just as easy in the real world. Hence, follow-up visits need to be planned at frequent intervals depending on the need and accessibility of the treatment centre to facilitate the change process. During the follow-up visits, adherence to the action plans and progress made need to be discussed.

His routine including eating and sleeping habits, efforts to maintain sobriety, mood-status – all may need to be discussed. These sessions are often used to look back and evaluate recovery.

The counsellor is often the only cheer-leader in the initial recovery period. The counsellor needs to be sensitive to progress made and appreciate him for the efforts he has taken. This strengthens his self-esteem and helps him view the future optimistically.

Two months of work without absenteeism, no further loans taken, the child awaiting his arrival, invitation to a relative's wedding – all these need to be considered as signs of recovery.

- Changes may need to be made if the plans don't work well enough. The decision not to do overtime may have to be relaxed for a week if there is shortage of staff at work. He may be able to attend only 3 N.A. meetings a week rather than one daily.

- The family members also need to be helped to accommodate the changes in the client. High expectations, casual remarks about the painful past and a controlling attitude by the family need to be altered.

- Clients need help to identify relapse indicators at thought, feeling and behaviour levels. Bringing these to client's notice and helping him strengthen his coping mechanism are important.

  "When you met drug using friends, earlier, you would just smile, wave and move on. Now, you seem to participate in short conversations. You are also missing out on your gym visits over the past two weeks. You mentioned just now, that life is just moving along and isn't interesting. Let us discuss about what is happening".

- Handling relapses is an important issue. Counsellors cannot view the patient's relapses as a sign of their own failure. The anger and frustration that grows out of it will limit the counsellor's ability to help the client.

The main issue is to arrest the relapse and initiate abstinence as soon as possible. Talking to the client or the family, making house visits, offering medical help or motivating him to receive help from the self-help groups helps.

- Relapse cannot be seen as the client's complete failure too. It rather indicates that there are areas that need to be changed and that further effort is called for. Being critical and using "I told you so" statements are not helpful. These only instigate the patient to be defensive. Rather the counsellor should convert his guilt and remorse in a constructive manner . Later on, the relapse process the issues that led to the relapse, and ways to prevent it in the future need to be discussed.

At this stage, the counsellor helps the client stay on track, maintain his focus on the goals, nudging him on to grow and actively intervene when he is heading in the wrong direction. When there is a relapse, the counsellor helps the client providing hope and enthusiasm for his recovery.

Stage 5 - Termination

All through the preceding stages the counsellor is preparing the client to grow so that he is not totally dependent on the counsellor any more. When the counsellor has repeatedly walked him through the process of problem identification, goal setting and changing, the client learns these skills that can be used by himself without the help of the counsellor.

Over a period of time, the client's social network gets strengthened and he is well integrated into the society. The counsellor actively encourages the client to handle issues on his own.

For most clients, termination takes place in 1 or 2 years of recovery. Casual contacts are maintained for a while longer. Keeping in mind the chronic nature of the disease, it is necessary to assure the client that help is available whenever he needs it. It is not uncommon to receive clients even after four to five years after recovery. They may come just to keep in touch, review the progress or sometimes hasten to take help fearing a relapse.

All through the five stages, the counsellor's skill is the primary force that keeps the client actively involved in therapy. In practice, however the client may not specifically progress from one stage to the other in a clear cut manner as outlined earlier. Instead one stage merges into the other and the client may move back and forth on certain issues. The strength of the counsellor lies in staying with the client, helping him stablilise and move forward. This process can be emotionally gratifying and professionally satisfying but can be frustrating too. The counsellor's emotional maturity to deal with set backs using the support of the team is of crucial importance.

In Summary

Counselling is a process with two overlapping phases. The first phase focuses on building a relationship that is characterised by rapport and trust. On the basis of this meaningful relationship, the client is helped to explore problem areas at the thought and feeling level, and identify goals of therapy. Planning, implementing strategies to overcome problems, evaluation and follow-up form the second stage of counselling.

The process of counselling

Assessment	⇒ current drug taking history ⇒ past history of substance abuse including use and abuse of alcohol ⇒ consequences of substance abuse in the areas of family relationship, occupational and financial functioning and legal issues ⇒ information about major medical problems in the past and present health status ⇒ co-existing psychiatric disorders ⇒ support available ⇒ previous treatment

Assessment is critical not only before treatment but also as an on going part of the process. Only by continuously assessing the client's progress and problems, can the counsellor accomplish the goals of therapy in the time frame available.

Initial sessions	⇒ identifying, focussing and prioritizing problems ⇒ working with the client to develop a treatment plan that requires the client's active participation ⇒ eliciting client concerns about problems and solutions ⇒ understanding client's expectations ⇒ explaining the structure of treatment including the process ⇒ making referrals for critical needs that have been identified but cannot be met with in the treatment setting (treatment for neurological problems etc.)

Subsequent sessions

The counsellor should help the client to set specific goals - total abstinence as well as improving the functioning in several areas of life.

Subsequent sessions	⇒ strengthen motivation ⇒ identify and enhance the skills, strengths and resources available to the client ⇒ address identified problems ⇒ monitor changes; to check whether the accomplishments are consistent with the treatment plan and the client's expectations ⇒ reinforce the changes made ⇒ assess further needs of the client and if need be referral to other centres (for example vocational training)

Maintenance strategies

Continuation of therapy is essential in maintaining abstinence and reinforcing improvement in the quality of life. The counsellor should continue to provide support, feed back and assistance in setting goals.

Maintenance strategies	⇒ educating the client about the chronic, relapsing nature of substance abuse disorder. ⇒ helping the client to identify relapse triggers and methods to deal with them ⇒ developing strategies for identifying and coping with high risk situations ⇒ teaching the client on methods to capitalize the personal strengths ⇒ developing a plan for future support in the form of self help groups, family support and community support

Ending treatment

Termination of therapy should always be planned in advance.

Ending treatment	⇒ provide a sense of hope for continued change and maintenance of changes already accomplished ⇒ leave the door open for possible future sessions dealing with the client's other problems ⇒ elicit commitment from the client to try to follow-up through on what has been learnt or achieved ⇒ review what positive outcomes the client can expect ⇒ review possible problems the client may encounter ⇒ mention the early indicators of relapse and strategies to deal with them

MH-2c.11

PERSONALITY DEFECTS

During drinking days, the patients would have developed certain negative personality traits. They might have had them even before, but with addiction these would have become exaggerated.

1. Selfishness –

Taking care only of one's own comfort and needs, without respecting the feelings and needs of others.

e.g. He would disturb his son who is studying for his exam, to buy him cigarettes.

He watches TV, unmindful of disturbing the children who are sleeping.

He would buy a new shirt for himself, not bothered to get the umbrella which the wife needs.

2. Dishonesty

Telling half truths and breaking promises are acts of dishonesty, just as lying is.

e.g. The patient would have received bonus or arrears in payments due, but he would not divulge this information to the family.

He would have taken a loan from his PF to repay the old debts but would tell his wife, his colleague paid the money.

3. Resentment

Resentment collected over the years leads to friction, hatred and unjust revenge. It leads to misery both for the patient and for others around him.

e.g. The brother-in-law warns about excessive drinking- the patient gets angry at the brother-in-law.

The supervisor gives a warning letter to the patient - he hates the supervisor for that.

Since the patient was under the influence of alcohol, the relative did not talk to him but spoke to his wife. When the relative came to invite him for the wedding in his family, the patient is angry with the relative.

All these incidents may have taken place years ago, but the patient still carries these memories and reacts.

4. Jealousy

Sadness at others' good fortune and making fun of their achievements often springs from jealousy.

e.g. Patient's colleague buys a new two wheeler by saving money - he ridicules his saving as a miserly act.

Brother-in-Law is a hard worker, takes care of his family, does not drink, smoke or play cards. He is ridiculed by the patient as that he does not know how to enjoy life.

The neighbour buys a plot of land by his sheer hard work. The patient teases him by saying, he is lucky to have brothers-in-law in Dubhai.

5. Procrastination

Putting off, and postponing things that need to be done right away- is a common trait. (I will do it tomorrow).

e.g. The patient has to buy train tickets for the family to go to an important wedding. He will keep postponing till the last minute. He cannot get the tickets, hence, he would make the family go in the unreserved compartment with lot of discomfort.

He will not pay the electricity bill till the last day . As a result he has to stand in the long queue for two hours wasting half-a- day's leave, while he could have paid the same in 10 minutes in the first week.

6. Impulsive behaviour

Making decisions without thinking, taking action without visualising the consequences.

e.g. Some of the impulsive decisions during recovery are buying things for children when they do not have sufficient funds or giving loans to friends.

7. Highly Sensitive

Feeling easily hurt, sensitive and touchy. But not sensitive to others' feelings - he does not mind hurting others.

e.g. While walking on the road, his brother-in-law would not have noticed his presence and not said hello. He gets upset. 'He has a good job that is why he is behaving in an arrogant manner', he mutters.

He would have gone for a wedding. A relative would say, 'I am glad you have given up alcohol. I want you to stay sober in the future also' - He gets hurt. 'As though, I am going to go on a binge', he feels.

8. Defiance

Not willing to accept any suggestion given by others (without examining the pros & cons).

e.g. Elder Brother suggests, "you need not take up sales job as you have given up alcohol recently". Since the suggestion has come from the brother, without even examining it, he goes ahead and accepts the job.

Wife would suggest, "Don't go for the friend's wedding in the night ; instead go in the morning (to avoid drinking friends)", but he would go just to spite her.

9. Wishful thinking

Lives in a dream world of his own, expects dreams to materialize without proper action.

e.g. Patient wants to go to Dubhai for a job. Always talks about his dream without making any practical plan to obtain a job or make money to go to Dubhai.

Action Plan for the Patient

It is important to develop qualities which will help the patient to lead a contented life and build relationships.

Courtesy - being gentle, respecting others

Cheerfulness - seeing beauty in life

Sincerity - genuineness

Kindness - showing care to others

Patience - work towards the goal, without worrying about the results

Gratitude - honest recognition of help received

MH-2c.12

GROUP THERAPY TECHNIQUES

Group Therapy has been acclaimed over the years as by far the most effective method of treatment for addiction. The gains of group therapy are now well established. Following are a few therapeutic gains that are unique to group therapy.

- Provides an opportunity to share and identify with others who are going through similar problems. Groups help in developing a sense of belonging.

- The spontaneous sharing of older members, of their progress and the changes they have achieved, instills hope in the new skeptical members.

- Helps clients in understanding their own attitudes about chemical dependency and their defences against giving up chemicals by identifying similar attitudes and defences in others.

- Verbalisation of thoughts and feelings, open feed back from others about positive and negative behaviour and being a witness to successful conflict resolution, helps them develop socialization skills.

- Teaches members interdependence (in contrast to dependence on chemicals) and thus build a better social network. This also helps chemical dependents to work through isolation.

- Provides a congenial atmosphere to powerfully confront denial, and assess high-risk situations. Members utilise the group as a laboratory for developing new responses and new skills.

- Provides an opportunity to formulate realistic goals and plans.

- Sharing insights, offering suggestions and support gives an individual the pleasant feeling of helping another. This altruism aids in strengthening self-esteem.

These gains prove that beyond doubt group therapy can be effective. The task then for the counsellor is to maximize the gains within the available time frame. Following are a few basic guidelines that contribute to effective group therapy sessions.

Size of the group

5 -10 members in a group is termed by Yalom as the `Acceptable Range'. When there are less than 5 members, it fails to function as a group; with more, it becomes unwieldy - both making it less effective.

Duration of the group meeting

A minimum of one to one and a half hour is needed for the group to settle down and get to work on an issue. However, if a group stretches beyond 90 minutes, fatigue sets in and diminishing gains are reported.

Frequency of meetings

Five group meetings a week is the minimum requirement. On discharge / follow-up, meetings may be held once or twice a week to strengthen changes made and offer support through the recovery process.

Physical environment

A pleasant quiet room, that ensures privacy is a pre-requisite for group therapy meetings. The seats should be similar and placed in a circle conveying that all are equal. Moreover, everybody is visible to the rest of the group; face to face interaction is made possible and non-verbal behaviour can be easily observed.

Rules and limit setting

At the beginning of the session, the counsellor has to clearly spell out basic rules like punctuality, regular attendance, staying for the entire session and not leaving midway, not attending under the influence of drugs. The following norms are a requisite as they help members function appropriately.

Confidentiality

Any information gained about another group member in the group therapy setting is to be treated in strict confidence. In short, "What happens in the group, stays within the group" should be repeatedly stressed.

Listening

Maintaining eye contact, being willing to listen to other person's feelings and words without interrupting, are important. Interruptions are not to be made unless

- the member is repetitious.
- the member is rambling without focussing on issues relevant to the topic of discussion.
- the listener has not understood and wishes to clarify his thoughts.

Using `I' Statements

`We' and `they' statements lead to superficial sharing on generalised issues. `You' statements usually turn into critical, judgemental ones. `I' statements, on the other hand, help him speak only for himself and own responsibility for his feelings, thoughts and behaviour. (Example: "I feel ashamed. I have hurt my parents").

Open, Honest, Spontaneous sharing

Group therapy offers an unique opportunity for handling issues. It should be emphasised that to maximise gains, wholehearted participation of the group is essential. Each member needs to remember that "the more he puts into a group, the more he will benefit from the experience".

All participants are considered equal, irrespective of their drinking/drug taking status, number of days they have stayed at the centre, or nature of the damage. The counsellor, as a facilitator of the group, need not share any details regarding herself.

Feedback

Guidelines for giving feedback

Feedback is an essential component of group therapy. The following are a few guidelines to be discussed with the clients prior to entry into the group:

- To talk about behaviour one can see.
  It should be specific and relevant.

  "I notice that you are late by 5-10 minutes everyday. So we are unable to start the group meeting on time".

- Feed back should be given caringly and not by hurting or attacking another member. No judgemental statements should be made.

  " I can see your problems. You continue to have many drug taking friends, and you have no access to N.A. meetings also".

- Members should avoid sarcasm and condescending remarks while giving a feed back. No advice is to be given – only responses.

  "You want to repay debts to the tune of One lakh in 6 months? You must be joking" – **Sarcastic remark.**

  "Listen to me. You cannot handle this. You better ask your wife."- **Advice.**

  "Let us plan out various methods and see how best it can be worked out" – **Proper response.**

- Members should be encouraged to share positive feed back also.

  "I am touched by your honest sharing".

Guidelines for receiving feedback

- Members should spontaneously ask for feed back and openly receive it.
- Excuses should not be given. Members should avoid defensiveness.
- Members should learn to acknowledge the value of feed back and express appreciation.

  "I am glad you have helped me see the positive qualities of my brother".

- Members should think and build upon the feed back given. They should view feed back as a continuing exploration.

The process of group therapy

Classically the group process can be divided into three phases. The early phase is the beginning of the group, particularly the first few meetings. The middle phase is the substance of the group, with the clients coming together, interacting, sharing, growing and changing in the counsellor's presence. The last phase is when the client completes the programme and leaves the group.

The first meeting

Group members are usually very anxious over their first meeting. As in any relationship, introductions are needed. The counsellor initiates the process by introducing herself, outlining the purpose of the group, and soliciting introduction from the clients. This can be done in several ways, of which the following is one example:

> *"I am glad that every one of you could make it. Let's get started. As you know my name is....... I want to tell you why we are here and what we will be doing in these meetings. Some of you know each other and others do not. One thing that every one has in common is being dependent on alcohol or drugs. This is going to be a time to get to know each other, learn about problems each one is facing, and find new ways to deal with them. At times we will talk about issues which may be sensitive like feeling lonely, depressed, problems at home etc. Here you will discover that you are not alone with these feelings and when you start sharing you will definitely feel less painful. Members here will help you minimise your pain."*

The introduction sets the tone for the group. In the above example we find the following messages:

1) A statement of purpose of the group
2) Identification of commonalty. This aids in developing unity in the group.
3) Disclosure of sensitive issues will be explored. It is vital that clients know such topics will be discussed.

4) Often they are overwhelmed by their problems and are disillusioned that no alternatives exist. Group gives them the much needed hope.

Introduction of clients can be done in many ways. When the suggestion is open ended i.e. "Let's say our names. Talk something about ourselves," the response may be either anxiety-ridden silence, or names rattled off in a rapid fashion with no mention of personal data. Introduction is the chemical dependent's first step towards self disclosure. They can be in a state of panic and can have a lot of anxiety. To get over this initial barrier, the following methods may be followed. First the group can be divided into pairs and each client asked to introduce himself to his partner. After this initial contact, they could come back, form a group and introduce the person each one met. This exercise helps the client take off direct focus on self. The second method of approach is to request senior members to introduce themselves first, thereby setting a role model for the new comers. After the introduction, the next step is to spell out group guidelines. These group guidelines have been discussed in the earlier part of the chapter.

Extensive clinical observations show how the group evolves and moves through three stages of growth. In general, a successful group will flow through them. At times, it may regress to the previous stage, but it will eventually move into the later stages.

Each stage is characterised by its own set of feelings and behaviour. Being familiar with these, will help the counsellor identify which stage the group is in, so that she can aid its moving successfully through its developmental stages.

Role of the Counsellor

The secret of making group therapy a powerful source for change is an art and a skill. Here as in a counselling relationship, the basic personality of the counsellor, her professional training and experience can make a world of difference. The counsellor has to maintain a relationship characterised by warmth, empathy, concern, acceptance and genuineness. An effective counsellor will be sensitive and flexible to the needs of the group and flow with it, all the while making valuable interventions.

- **Helping members belong**

  The group therapy situation may be stressful for the new comer. The members are strangers to each other and look at the counsellor as the unifying force. By using this "special member" status, the counsellor goes on to create one physical entry – "a group" from a collection of members with different experiences and problems.

  Being sensitive, accepting and supportive to all members and displaying this through appropriate verbal and non-verbal behaviour, the counsellor can create a sense of "oneness" or "togetherness".

  Late coming, absenteeism, sub-grouping (two or three members carrying on interactions while actively excluding others) and "scape goating" (majority of the group making one member the target of their negative feelings) threaten cohesiveness. The counsellor should act early and decisively to counteract these forces.

- **Encouraging "Feeling Level" Interaction**

  Feelings of shame, guilt, resentment and fear are the predominant negative emotions. Being able to talk about them in a supportive, caring environment to people who have actually experienced them, is what makes group therapy effective. Handling anger and resentment means getting to grips with the underlying true feelings. Members who are eloquent, may find it easy to share on a superficial level. By encouraging and emphasising "feeling level" statements, the counsellor can help them get in touch with their negative feelings, which they try to run away from. Separating thoughts from feelings and labeling feelings, helps them explore further and deal with them better. This exercise stands them in good stead in their future communication patterns and problem solving efforts.

MH-2c.13

MEDICAL AND PSYCHIATRIC COMPLICATIONS RELATED TO ADDICTION

Drug abuse has a deleterious effect on specific organs of the body. In addition to this, the poor eating habits, irregular sleep patterns, poor health care and inordinate delay in seeking medical help only serve to worsen the situation .

The type of drug abused and the duration influence the amount of damage caused. Medical and psychiatric manifestations depend on the following factors:

a) Age: The damage is higher among the very young whose bodies are still in the process of growing up and in the older age group for obvious reasons.

b) Nutritional status and living conditions: The health damage is more among the economically weaker sections.

c) Health condition prior to abuse: The damage is less among individuals whose physical condition is good when compared to individuals whose health was poor even before the onset of addiction.

d) Genetic loading factor: The substance abuser with a genetic pre-disposition or a family history of specific medical or psychiatric problems is more susceptible to that particular problem. For example, a family history of schizophernia further hastens the psychiatric breakdown of a ganja abuser.

Medical and psychiatric complications can be studied under four major heads.

a. Problems due to intoxication
b. Problems due to withdrawal
c. Psychiatric disorders associated with substance abuse
d. Systemic disorders associated with substance abuse

PROBLEMS DUE TO INTOXICATION

Intoxication is a transient condition resulting from recent use of a psycho- active substance at a sufficiently high dose level. Impaired attention, judgement and interference with personal functioning can cause any of the four problems.

1. Trauma or other physical injury

a) Mood changes caused by drugs incite negative feelings leading to violence. Street brawls and gang-fights are often initiated and carried out under the influence of drugs and alcohol.

Driving vehicles or operating machinery under the influence of alcohol / drug cause accidents and injury. Poor motor coordination and a disregard for safety guidelines due to intoxication are the cause of about 50% of our road accidents and a large number of industrial accidents.

c) Physical injury or death due to crossing railway tracks, falling from high places and other risky behaviour due to poor judgement of time and space are also commonly reported.

d) Head injuries are very common. They may cause permanent brain damage. Difficulty in comprehension and memory or even strokes can follow.

2. Perceptual distortions

Drug intoxication can make a person delirious and disoriented. Irritability, rapid fluctuations in mood and impaired attention may set in. He may hurt himself or others in this state.

3. Acute intoxication reaction

Reaction depends on the type of drug abused. Narcotic analgesics can cause apathy, sedation and psychomotor retardation. Cannabis can cause agitation, suspiciousness, hallucinations and feelings of depersonalisation. With depressant drugs, vomiting or convulsions can occur.

Given time, the acute intoxication wears off. If he is agitated, he needs to be watched carefully as he may harm himself or others.

Forcing him to eat or drink when he is in the stage of intoxication is risky. Food particles can enter the lungs causing him to choke on it and die. Severe lung infections also can develop due to aspiration of food into the lungs .

4. Coma and overdose deaths

The quantity of drug intake is steadily increased due to tolerance. While tolerance develops to effects like euphoria, the increased drug intake may be too high and produce respiratory depression, coma and death.

The purity of illegal drugs like heroin can only be guessed. He may use the same quantity of drug as usual but unknowingly take an overdose if the quality is superior. IV narcotic abusers are highly prone to over dose deaths of this kind.

Combination of alcohol and sleeping pills is particularly dangerous. While alcohol is readily absorbed and effect is felt immediately, sleeping pills take longer to act. The user may continue to drink alcohol under the impression that he is not 'high' enough. Later, when the sleeping pills start acting on the brain, the overdose can result in death.

PROBLEMS DUE TO WITHDRAWAL

Physical withdrawal symptoms of varying intensity occur as part of withdrawal differing according to the drug abused. It is now understood that the intensity of withdrawal symptoms has been blown out of proportion and in reality is not as painful and uncomfortable as it was previously made out to be. Offering psychological support and symptomatic treatment is seem as being most effective.

It must of course be remembered that the patient's age and physical condition need to be taken into consideration. Delirium tremens, the most severe form of withdrawal can be accompanied by medical emergencies and should be handled carefully.

PSYCHIATRIC DISORDERS ASSOCIATED WITH SUBSTANCE ABUSE

Psychoactive substances can induce psychotic disorders either during or immediately after their use, with one or more of the following symptoms:

a) Psychomotor disturbances: The patient may be restless and agitated or may stay immobile

b) Disorientation : He may not be able to identify people, the place where he is in or the date, day or time.

c) Hallucinations: Auditory hallucinations and visual hallucinations are most common. Tactile or olfactory hallucinations though rare, may occur.

d) Persecutory delusions : He may complain that people are trying to harm him or plotting against him.

e) Ideas of reference : He may report that others are talking about him and state that he is being discussed in books or even in the television.

f) Abnormal emotional response ranging from intense fear to ecstasy that has no relationship to what is happening in reality.

Cannabis abuse can particularly trigger off neurotic and psychotic disorders. Anxiety, panic attacks or depression can set in due to cannabis abuse. There has been cases reported where even a few doses of cannabis has produced a psychiatric breakdown.

Drug induced psychotic states are usually of short duration resolving at least partially within a month and fully within six months.

SYSTEMIC DISORDERS ASSOCIATED WITH SUBSTANCE ABUSE

1. Dermatological complications

i) Septic coetaneous complications:

a) needle tracks can be caused on injection sites

b) tattooing and scaring can occur due to the presence of foreign bodies in the needle used. Addicts may heat the needle on fire to clean it and carbon deposits can settle on the needle causing this.

c) abscess formation due to infection can develop on injection sites.

d) cellulitis -infection of the skin which appears as a red inflamed patch can develop.

ii) Other skin problems:

a) Pruritis: Narcotic analgesics can cause itchy skin and scratching can lead to infection.

b) Dermatitis: Inflammation of skin due to infection or allergy also can occur.

c) Acne Rosecia (large boils on the skin) and rhinophyma (red and enlarged nose) known as brandy nose can be caused due to alcohol abuse.

2. Cardiovascular complications

a) Endocarditis: Infection of the lining of the heart and the valves can occur among IVDUs.

b) Cardiomyopathy: Muscles of the heart are enlarged and cause dysfunction.

c) Thrombo phlebitis: Repeated infection at same sites causes the development of thrombus in the veins affecting blood circulation.

d) Embolic phenomena: The presence of air bubbles or thrombus that forms in the veins can cause embolus to develop. This embolus can move into the blood stream, lodge itself in any part of the circulatory system and cause problems.

Myocarditis: The muscles of the heart are inflamed and may become permanently damaged.

f) The intensity of the drug induced effect on the heart can cause ventricular fibrillation or hemorrhage and sudden death. This is common among IV drug abusers as well as due to amphetamine and volatile substance abuse.

Pulmonary complications

a) Multiple micro infarcts: Among IV drug abusers, the embolus that enters the blood stream can lodge itself in the lungs and interfere with its functioning.

b) The embolus can also cause death of some cells in the lung leading to pulmonary fibrosis which again affects the functioning of the lungs.

c) Pulmonary oedema: Fluid can collect in the lungs and cause breathlessness

d) Aspiration pneumonia : Due to drug effects the reflexes may be poor and the food particles may enter the wrong way causing pneumonia.

e) Pharyngitis, bronchitis, pneumonia and tuberculosis are common infective respiratory diseases among drug abusers. Reduced immunity, poor medical care, poor nutritional status and poor hygiene increase the risk of these infections.

4. Hepatic complications

a) Hepatitis: Infections of hepatitis B and C are common among IV drug abusers due to sharing of needles. Nausea, vomiting and other typical signs of jaundice are seen. Intake of alcohol in excessive quantities can cause inflammation of liver cells leading to alcoholic hepatitis.

b) Fatty liver can develop due to alcohol abuse. This condition is easily reversible if alcohol intake is discontinued.

c) With continued excessive intake of alcohol, alcoholic cirrhosis can develop. Healthy liver cells are replaced by scar tissues and the liver slowly loses its ability to work, causing jaundice, accumulation of fluid in the abdomen, feet , wasting of muscles etc. The damage caused is permanent and cannot be reversed.

Among IV drug abusers, infections that passed through unclean needles can kill liver cells leading to post necrotic cirrhosis. (nausea, vomiting and signs of jaundice)

5. **Complications in the reproductive system**

The incidence of many kinds of sexually transmitted diseases are common among drug abusers. Lowering of inhibition, loss of value systems and prostitution for money to buy drugs are responsible for the casual attitude to sex, increase the risk of infection.

b) Narcotic analgesic and depressant drugs reduce one's sex drive and cause other sexual problems as well.

c) Alcohol and cannabis can produce impotency by reducing the level of sex hormones.

d) Menstrual abnormality is noted among female drug abusers.

e) Children born to mothers who abuse drugs and alcohol during their pregnancy usually have low birth weight and other problems in the physical and mental development. Newborns can also go into withdrawals soon after birth.

6. Neuromuscular complications

i) Non-infectious neurological problems

a) Cerebro-vascular accidents: The embolus (due to air bubbles or thrombosed veins) can reach the brain and cause damage. Depending upon the place where this emboli settles in , the neurological deficits will be mild or severe.

b) Chronic organic brain dysfunction (dementia) : Repeated impact of drugs/alcohol on the brain cells can cause permanent brain damage. The abuser's cognitive function is reduced and new learning becomes difficult.

c) Wernicke-Korsakoff's syndrome: Excessive alcohol intake and associated thiamine deficiency causes degeneration of the brain cells. Tremors, poor balance and coordination, involuntary movement of eye balls and loss of memory occur.

d) Neuritis : Tremors, tingling, numbness and pain in extremities develop due to the damage caused to the nerve fibres.

ii) Problems due to infections

a) Bacterial meningitis: The covering layers of the brain can be infected by use of unsterile needles.

b) Abscesses can develop due to infected needle use and cause degeneration of brain cells and pus formation.

Drug/alcohol abuse can affect the functioning of the liver badly. Hepatic coma can set in . Following this, all the systems in the body breakdown and death ensues

7. Haematopoietic complications

a) Drugs can damage the liver directly and reduce the platelet production which cause drugs abusers to bleed easily.

b) Bone marrow depression is common in solvent abusers.

c) Reduction in white blood corpuscles occurs in ganja abusers and alcoholics causing reduction in the level of immunity.

d) Megaloblastic anemia due to folic acid deficiency develops in alcoholics.

d) Bacteremia: Infections due to unsterile needles can spread anywhere in the blood and lymphatic system and can cause lymph node enlargements.

8. Endocrine system disorders

a) Ganja, opiates and alcohol abuse lowers the testosterone levels in the body causing sexual dysfunction.

b) Incidence of diabetes milletus increases among alcoholics.

9. Renal functioning disorders

Nephropathy : Infection of the cells in the kidney can set in and damage it permanently.

10. Gastro-intestinal disorders

a) Gastritis and peptic ulcers can develop due to poor food habits as well as due to the effect of the drugs abused.

b) Chronic pancreatitis develop due to damage of the pancreas in the alcoholic

c) Cancer due to abuse of alcohol

11. Other complications

a) sharing of needles can lead to spread of HIV, serum hepatitis, malaria and tetanus.

b) incidence of cancer also increases with abuse. Cannabis addicts are particularly prone to cancer of the respiratory system.

Gout like syndrome due to increase in uric acid level is common among alcoholics.

Drug abuse thus clearly interferes with the functioning of the body. These complications need to be explained in detail to the drug abuser and the family members to make them cautious and seek ways to overcome addiction as well as the medical problems present.

MH-2c-14

CLASSIFICATION OF DRUGS – SHORT-TERM, LONG-TERM EFFECTS AND WITHDRAWAL SYMPTOMS

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

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

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

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

Drug abuse leads to drug addiction with the development of tolerance and dependence.

Tolerance refers to a condition where the user needs more and more of the drug to experience the same effect. Smaller quantities, which were sufficient earlier, are no longer effective and the user is forced to increase the amount of drug intake.

Slowly, drug dependence develops. Some drugs produce only psychological dependence while others produce both physical and psychological dependence.

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

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

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

Symptoms of drug withdrawal tend to be the opposite of the effects produced by the presence of the drug in the body. For example, brown sugar intake causes constipation, while the effect of withdrawal from brown sugar is diarrhea. These withdrawal symptoms make it difficult for the user to give up drugs. He wants to avoid the unpleasant withdrawal symptoms; and to avoid them he needs the drug. He is thus forced to continue the drug use even when he knows that drugs are hurting him.

CLASSIFICATION OF ADDICTIVE DRUGS

Substances that are abused can be studied under seven major categories

Narcotic analgesics

Cannabis

Depressants

Hallucinogens

Stimulants

Volatile solvents

Other drugs of abuse.

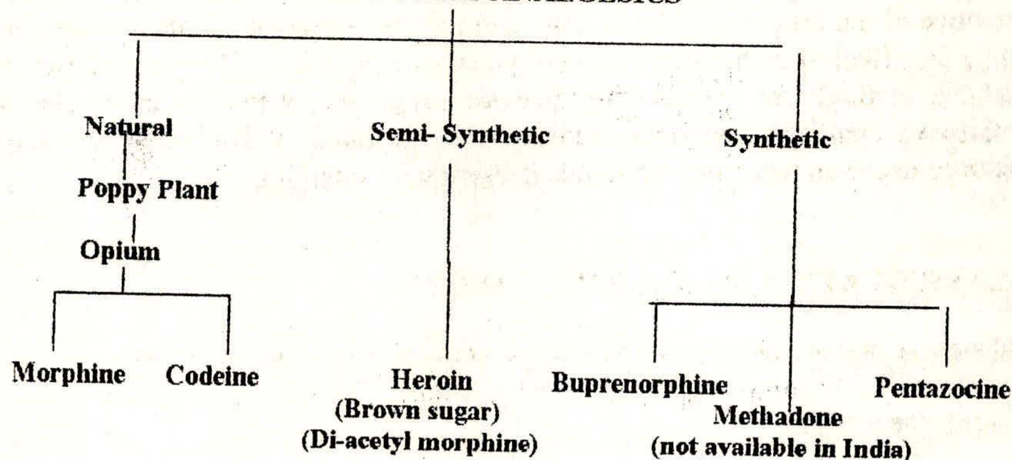
Note: For a long time cannabis was classified as a hallucinogen. But since a few effects like flashbacks do not occur with cannabis a separate category was created.

NARCOTIC ANALGESICS

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

All narcotic analgesics share the common property of benumbing and thus relieving pain. As a class, they are painkillers with a high addictive potential. Certain narcotic analgesics are clinically employed for other actions including suppression of cough and control of diarrhea.

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



Narcotics of natural origin

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

Opium

The word 'opium' is derived from the Greek word, 'opion' meaning 'poppy juice'. Opium is obtained by tapping the milky fluid from the unripe poppy pods. It is a dark brownish or dark greyish tar-like substance with a musty odour. It is usually sold in the form of small balls, lumps or bricks.

Routes of Administration

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

Inhalation: Opium can also be smoked. A special piece of equipment, (sometimes simple but generally elaborate) is used by opium smokers. It is smoked in the reclining posture to reduce the feeling of nausea. The infamous 'opium dens' of yesteryears are non existent today. Opium is now smoked alone or in groups in their own houses.

Morphine

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

Route of administration

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

Codeine

Codeine is another alkaloid found in opium, though in a smaller percentage than morphine (one to two percent).Codeine is used as a cough – suppressant. Cough syrups containing Codeine are now being abused in many parts of India.

Route of administration

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

Semi-synthetic narcotics

Heroin/Brown sugar

Heroin belongs to the category of narcotic analgesics and is a semi-synthetic derivative of the drug morphine.

Pure heroin is white crystalline powder and it is referred to as 'white sugar' by the abusers. When the quality of heroin is poor, its colour is no longer white, but rather brown, and this inferior quality is referred to as 'brown sugar'.

Routes of administration

Injected: The drug is dissolved in lime and water and injected subcutaneously or intravenously. Among the intravenous users, an immediate high (rush), described as akin to an orgasm, is reported. Heroin is rarely snorted.

Inhalation: Smoked with tobacco in cigarettes.

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

In general, brown sugar is not taken orally. Narcotic analgesics, being alkaline in nature, are not absorbed in the acidic medium of the stomach. In the intestine, the heroin molecules quickly conjugate (attach) to other molecules, making absorption difficult. The little that gets absorbed must pass through the liver before getting into the bloodstream.

The liver quickly destroys the drug thereby drastically reducing its potency. It is estimated that about 90% of the effect is lost when taken orally.

Synthetic narcotics

Synthetic narcotics are produced only in the laboratory. These drugs imitate the effects of the opiates but are not prepared from opium. Buprenorphine and pentazocine are the most widely abused synthetic narcotic drugs.

Buprenorphine and pentazocine

Both are synthetic narcotic analgesics which are used as pain killers in a wide variety of medical conditions.

Buprenorphine (Tidigesic) was initially used to treat the withdrawal symptoms of heroin addiction as well as in the treatment of cancer. Later, it became a drug of abuse.

Routes of administration

Oral: Administered orally in the form of tablets.

Injected : Subcutaneously, intramuscularly or intravenously. Addicts almost always inject the drug intravenously.

Metabolism

Distribution

Narcotic analgesics are not absorbed evenly by all the parts of the body. They concentrate in the tissues especially in the kidneys, liver, skeletal muscle, lungs and spleen. Only small amounts of narcotic analgesics cross the blood brain barrier (BBB) but the central nervous system is so sensitive that even minute amounts are sufficient to cause a pharmacological effect. Small quantities of the drug cross the placental barrier, and fetal dependency can develop.

Excretion

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

Short - term effects of narcotic analgesics

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

The main effects include:

a short-lived state of euphoria during which feelings of hunger and pain are not felt.
mental clouding, impairment of intellectual processes
drowsiness, sedation, apathy, decreased physical activity

A few other adverse reactions may also appear

- vomiting in novice users
  dysphoria (a feeling of unpleasantness)
  inability to concentrate
  itchy skin
  constipation
  constriction of pupils (with the exception of synthetic narcotics)

After the initial effect wears off, there is an increased sensitivity to pain.

Severe overdose of heroin results in very slow, shallow, irregular breathing, marked decrease in blood pressure, cyanosis (body becomes cold and bluish) and coma. Death usually occurs due to respiratory arrest or cardio-vascular complications.

System effects

Central Nervous System

Pin point pupils, droopy eye-lids, reduced visual acuity
Decrease in REM sleep (rapid eye movement-the rapid, jerky movements of the eye which occur during certain stages of the sleep cycle when dreams occur). In the REM stage of the sleep cycle, sleep is most beneficial to the body as the body is most relaxed at that time.

Respiratory System

Respiratory depression due to the effect on the respiratory centre in the brain .

Cardio-Vascular System

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

Gastro Intestinal tract

Constipation and poor appetite

Kidneys

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

Long-term effects

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

In addition, the following complications can develop:

- Serum hepatitis/HIV/AIDS caused by use of infected needles

Fetal addiction can develop. 80% of the babies born to addicted mothers develop withdrawal symptoms such as hyper activity, irritability, tremors, regurgitation, poor feeding and diarrhoea. Convulsions may also occur. These children usually have low birth weights.

Tolerance and dependence

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

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

Powerful physical and psychological dependence develop. Abrupt cessation of the drug use leads to withdrawal symptoms.

Withdrawal symptoms

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

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

Delirium occurs in drug withdrawal only in the case of severe infection anywhere in the body.

CANNABIS

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

More than 60 constituents, known as cannabinoids, occur naturally in and only in the cannabis plant. The chief psychoactive substance among them is delta-9-tetra-hydrocannabional-commonly referred to as THC.

The main drugs under this category include

Ganja/Marijuana

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

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

Route of administration

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

Hashish / Charas

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

Hashish ranges in colour from light brown to almost black and the THC content in hashish ranges from 5-15%.

Route of administration

a. Hashish is smoked and sometimes baked with food and eaten.

Hashish Oil

Hashish oil is produced by a process of repeated extraction of the resin of the cannabis plant to get a high concentration of THC. It is highly potent with a THC concentration ranging from 20% up to even 60%. Hashish oil is a dark viscous liquid.

Route of administration

a. It is usually dripped on cigarettes and smoked.

Bhang

This is the least potent of all cannabis drugs. Bhang contains the dried parts of the plants-leaves and stem. Bhang is brown leafy material with dried twigs.

Route of administration

a. Bhang is usually brewed with tea or milk and drunk.

Metabolism

Distribution

When cannabis drugs are smoked, less than 50% of the THC is absorbed and enters the blood circulation. The effects are felt within minutes. The effects peak after 10-30 minutes and action ceases after 2-4 hours.

When taken orally the effects are felt after 1 hour and the peak is reached only after 5-6 hours and effect lasts for 10 hrs. Users prefer to smoke the drug, at it is about three times more potent when compared to the oral route of administration.

Excretion

After its absorption, THC rapidly leaves the blood and enters the body organs. THC enters the fat tissues from the blood. From here they pass back to the blood and reaches the liver to get metabolized. THC is metabolized by the liver into more water soluble compounds so that it can be excreted. Some of the metabolites (products of metabolism) which are produced are also psychoactive.

Short term effects

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

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

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

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

System effects

Cardiovascular system

Tachycardia (increased heart beat) is very prominent. Due to dilation of blood vessels in the conjunctiva, reddening of the eyes can be noticed. There is fall of blood pressure also.

Respiratory system

Irritation of the mucosal membranes lining the respiratory system and broncho dilation.

Gastro-intestinal system

Increased appetite for sweets.

Long term effects

Pronounced psychological dependence is particularly high among users with emotional problems.

Amotivational syndrome: The user may lose all interest in his work, family etc. He may become so apathetic that he is not interested in any goal oriented activity.

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

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

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

Children born to a mother smoking cannabis during pregnancy may have low birth weight or mental retardation.

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

Tolerance and dependence

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

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

Withdrawal symptoms

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

DEPRESSANTS

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

Sedative-hypnotics
Alcohol

Sedative-hypnotics

Sedative-hypnotics are depressant drugs whose primary effects are calming, sedating or inducing sleep. Barbiturates like Methaqualone (Mandrax), Secobarbital & Amylobarbital (Vesparax), and Benzodiazepines like Diazepam (Valium, Calmpose) and Lorazepam (Ativan) are the commonly abused drugs.

Routes of administration

Sedative hypnotics are administered orally in the form of tablets or capsules. They can also be injected-subcutaneously, intravenously or intramuscularly.

Alcohol

Alcohol is a clear, thin liquid, with a harsh burning taste. It is the product of fermentation and distillation. Ethyl alcohol (C_2H_5OH) is the intoxicating substance present in alcoholic beverages like beer, whisky, rum., brandy, wine, etc. It supplies empty calories - calories without any nutritive value whatsoever.

Route of administration

a. Taken orally.

Metabolism

Distribution

Alcohol is absorbed as soon as it enters the stomach. Unlike other food, alcohol does not need digestion. After ingestion, it is carried to the stomach and small intestines and through the walls of the stomach gets into the blood stream, from where it is carried to almost all the organs including the brain.

With alcohol, the rate of absorption is not constant, but depends on various factors like the speed of drinking, concentration of alcohol taken, the amount of foodstuff in the stomach, etc.

Intake of 1-2 drinks (1 drink = 30 ml. of whisky / brandy) depresses the higher centres in the brain. Inhibition are thus lowered. The user feels more relaxed and seems to be able to talk more freely. As more amount of alcohol is consumed, fine motor coordination is affected, reaction time increases and judgement becomes poor. This is what makes driving under the influence of alcohol a dangerous activity. As the alcohol content in the blood continues to increase more and more centres in the brain are affected. If the user continues to drink, double vision and loss of balance are evident. When he has had too much of alcohol, he loses consciousness. This is nature's way of protecting him because if he continues to drink the respiratory centre in the brain will also shut down.

Excretion

In the liver, alcohol undergoes the process of oxidation whereby it is changed into carbon dioxide and water and energy is released. The waste products are excreted through the lungs and the kidneys.

System effects of alcohol abuse

CNS changes

Wernicke-korsakoff syndrome (characterised by disorientation, peripheral nerve damage, loss of muscular coordination and involuntary, horizontal rapid eye movements) confabulation (contriving stories to fill in gaps in memory)
Alcohol dementia (disturbances in thought and memory cognition)

Other effects

Gastro-intestinal problems include gastritis, peptic ulcer and cancer.
Fatty liver, hepatitis and cirrhosis. Also there is an increased likelihood of liver cancer
- Pancreatic effects include pancreatitis, diabetes.

Muscle weakness and wasting are commonly seen
Cardio vascular effects of alcohol include damage to the heart muscles
Blood cells (both red and white) and platelets are affected
Kidney problems include diuresis and gout

- **Sexual dysfunction both in males and females**

Short-term effects of depressants

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

relief from anxiety and tension
euphoria (usually with barbiturates)
lowering of inhibitions
sedation, sleep with larger doses
poor motor coordination (especially for fine motor tasks)
impaired concentration and judgement
slurred speech and blurred vision

Nausea, abdominal pain, excitation which may lead to hostile behaviour can occur. Large doses can cause irregular breathing, weak pulse. Coma and death due to over dose can occur and occurs with a combination of sedative hypnotics and alcohol.

Long-term effects of depressants

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

Tolerance and dependence

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

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

Physical and psychological dependence develop. Craving, anxiety or even panic is evident if the user is temporarily unable to obtain supply of the drug.

Withdrawal symptoms

Withdrawal symptoms like anxiety, insomnia, weakness and nausea are usually noticed. With very high and chronic use, agitation, high body temperature, delirium, hallucinations and convulsions develop.

HALLUCINOGENS

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

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

LSD (Lysergic acid diethylamide)

LSD is a semi-synthetic drug and the most powerful hallucinogen. It is produced from lysergic acid, a substance derived from the ergot fungus which grows on rye, or from lysergic acid amide, a chemical found in morning glory seeds. LSD is used only as a research tool to study the mechanism of mental illness. LSD has no medical use.

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

Route of administration

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

PCP (Phencyclidine)

PCP is synthetic drug produced only in clandestine laboratories.

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

Routes of administration

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

Mescaline

Mescaline is derived from a type of cactus and is also produced synthetically. Mescaline appears as a white or coloured powder.

Route of administration

a. The oral route of administration is most common.

Psilocybin

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

Route of administration

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

Short-term effects of hallucinogens

The physical effects produced and perceptual effects created differ from one drug to another. The main effects include:

Alterations of mood- usually euphoric but sometimes severely depressive.

Distortion of the sense of direction, distance and time (e.g. passage of a few minutes may seem like hours)

Intensification of the sense of vision. Colour and texture of items become more vivid and perception of details is increased.

'Psuedo' hallucinations ('pseudo' because the user knows that the experience is not true e.g. seeing a myriad of colours or bizarre images).

Synesthesia (melding of two sensory modalities). User may feel he can see music, hear colours etc.)

Feelings of depersonalisation, loss of body image and loss of sense of reality (the user may feel that his body is shrinking or becoming weightless).

Sense of the past, present and future may be jumbled. Concentration becomes difficult and attention fluctuates rapidly.

Vague ideas and extreme preoccupation with philosophical issues are common. The great truths and insights he believes that he has discovered are unintelligible or nonsensical to those not under the influence of LSD.

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

Self destructive behaviour due to rash decisions and accidents due to impaired judgement are common.

Long-term effects

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

A motivational syndrome: The user becomes very apathetic, is very passive and shows no interest in life.

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

Tolerance and dependence

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

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

STIMULANTS

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

Amphetamines

Amphetamines are synthetic drugs produced entirely within the laboratory. Amphetamines are used in other countries to treat narcolepsy (an uncontrollable tendency to sleep) and sometimes in weight control programmes. Ecstacy is an amphetamine based drug currently being abused in the developed countries.

Amphetamines are not abused in India today, even though in the late 70s, they were being used by

students to ward off sleep, enabling them to study through the night, prior to the examination

athletes, to mask feelings of fatigue and increase their endurance

Route of administration

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

Cocaine

Cocaine, a potent stimulant of natural origin, is extracted from the leaves of the coca plant (Erythroxylon coca). It is an odourless, white crystalline powder, with a bitter numbing taste.

Cocaine was formerly used in eye, nose and throat surgery because of its ability to anaesthetize tissues and simultaneously constrict blood vessels and limit bleeding. Now it is not used medically.

Crack

This is made from cocaine and is widely abused in developed countries like USA. Cocaine and crack being enormously expensive, are not abused in India as yet.

Routes of administration

Oral: The leaves of the coca plant are sometimes chewed and cocaine, the chief psycho-motor chemical present, is absorbed through the mucous membranes of the mouth. Very rarely, cocaine is injected for a heightened effect.

b. Snorted: Usually 'snorted' or taken in through the nasal passages (like snuff).

Short-term effects of stimulants

Amphetamines and cocaine have different mechanism of action; but the overall impact is the same and their effects parallel each other.

The main effects include

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

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

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

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

Long-term effects

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

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

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

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

Tolerance and dependence

It produces both physical and psychological dependence. Tolerance does develop to a certain extent. As the intensity of the pleasurable effects is high, strong psychological dependence also develops.

Withdrawal symptoms

Withdrawal symptoms occur, however the clinical picture does not include major grossly observable physiological disruptions. Extreme fatigue, prolonged but disturbed sleep, voracious appetite, irritability and moderate to severe depression are the commonly reported withdrawal symptoms.

VOLATILE SOLVENTS

Drugs belonging to this category are volatile hydrocarbons and petroleum derivatives like petrol, paints, nail polish remover, ether, glue, benzene, varnish thinner and lighter fluid. This form of substance abuse is primarily found among younger people who are less than 18 years of age . Abuse of volatile solvents is rare in India but has been reported among the street children.

Route of Administration

a. Inhalation by sniffing the foresaid substances.

Short-term effects

Behavioural effects include euphoria, clouded thinking, slurred speech and staggering gait. Hallucinations occur in about 50% of the abusers. The effects are about the same as for sedative hypnotics and many youngsters who abuse these substance end up dependent on alcohol or other sedative type drugs.

Sudden death can occur due to sniffing these drugs.

Long-term effects

Long term effects include psychosis and permanent brain damage. Tachycardia with possible ventricular fibrillation can occur. Damage to the liver, kidneys and heart is also possible.

OTHER DRUGS OF ABUSE

There are a few other drugs of abuse that do not belong to any of the above categories.

Abuse of the following drugs has been reported;

Muscle relaxants like carisoprodol. (e.g. carisoma compound). The drug is available in the form of tablets and abused for its depressant effects that resemble those of alcohol and other sedative hypnotics.

CNS analgesics like dextropropoxyphene (e.g. proxyvon) and extropropoxyphene in combination with dicyclomine (e.g. spasmoproxyvon). Tablets and ampoules are available. The drug is taken orally or intravenously . The pain relieving effects are very pronounced.

These drugs are prescribed usually to relieve pain following accident trauma or surgery. When its use is not carefully monitored by the supervising physician addiction can develop.

Antihistamines like chlorpheneramine maleate (e.g. avil)

Anti-emetic like promethazine (e.g.phenargan)

Both these categories of drugs are usually abused in combination with narcotic drugs like heroin or buprenorphine to enhance the effects .

e. Anti-depressant drugs like amineptine (e.g. survector)

These drugs are abused for its sedation effects. Prescriptions need to be issued very carefully to watch out for signs of tolerance. In case of tolerance, most physicians opt to shift the patient to other category of the anti depressants that do not produce sedation.

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MOTIVATION AND INTERVENTION TECHNIQUES

Addiction is the only disease where the victim does not fully realise the enormity of his problem. The stigma associated with drug use, the guilt and shame resulting from inappropriate use and the lack of awareness about the part drugs play in the problems they face - all these lead to denial of the problem of addiction. In an attempt to protect the dignity of the family, in most of the cases the family members also deny the existence of any serious problem. So motivation becomes one of the key issues in the treatment of chemically dependent people.

What is motivation?

'Motivation' is creating the desire to change one's own dysfunctional behaviour and 'motive' is the energizing condition that directs the individual to achieve the goal. Motivating the addict to accept help forms the first phase of treatment.

Family intervention

The first person to call for help is generally the parent or wife - the person closest to the abuser, one who is more worried, afraid and angry than the others. At this juncture, the family member's crucial fear will be "How do I bring him to the treatment centre?" To help the family intervene, the counsellor has to provide information about addiction. The family member has to understand that addiction is a disease and that it requires treatment. She has to be shown how the enabling behaviour of the family has led to the continuation of the problem. She has to see the role she has unknowingly played in maintaining the process.

Making use of a crisis

She has to be guided to motivate the patient to accept help. What is it that she can do? Addicted individuals 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, most of them are open to help, mainly to tide over the crisis. She has to look for some crisis and make use of it. For instance, the addict would have suffered severe pain in the stomach, or would have received a letter of warning from the office. The family can use this crisis to make him see the problem and accept help.

Involving others

To make the intervention more effective, as the next step, the other members in the family for whom the person has regard and respect can be involved.. Their involvement in the process will increase the motivation of the individual. In this group it is important to include the addict's children also. Most often they are the ones who witness the fights, face the anguish and end up bearing the family's pain. Friends, relatives, employers, doctors and others may also be included.

A list of specific, non-judgemental facts relating to the abuse of drugs should be presented to the patient when he is drug free, particularly, immediately after the crisis, in a caring manner by these members. The following chart shows the details to be presented and the manner in which it has to be done.

A	Non-Judgmental attitude reflecting care and concern	Avoid looking down on the person or making moral judgements. The person reporting the data should also be encouraged to indicate how it makes her feel –such as embarrassment, fear, unhappiness, etc. `Alcohol is destroying your health. When we see your health deteriorating , it is upsetting for all of us'. 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.
B	Specific details	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. `Mohan also told me you are taking drugs all the time'. Instead stick to factual reporting of behaviour and incidents.  Avoid generalisation such as `You have always given me problems since your childhood'.
C	Plan of action	Decide beforehand as to what type of help you want the patient to get. If the addict does not accept this, have an alternative course of action.
D	Consequences	What alternatives does the person face if he rejects all forms of help? Some of the consequences could be highlighted – loss of job, mounting debts, marital separation etc. Do not state conditions that cannot or will not be carried out.

There may be addicted individuals who do not respond to any of the above stated motivational / interventional procedures. For them, the emotional acceptance of the fact will take a very long time. Instead of rejecting the patient or confronting him with logic and argument, the significant others involved in the process of intervention, should reassure him that they are always there to help and support him if he decides to go for treatment.

Professional intervention

Generally after these interventions, the patient comes asking for help. The counsellor's most important task during the first interview is to establish a positive relationship. Her understanding, non-condemning, non-judgmental attitude, her acceptance of the patient, will in turn, help the latter to accept himself. Once the person feels accepted, it will be relatively easy for him to discuss his problems freely, the mere mention of which would have irritated him earlier.

Alleviating fears

The patient would already have tried (though unsuccessfully), to stay away from drugs. He would have experienced problems associated with withdrawal. He 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. This addicted individual may already have taken treatment in various centres, and failed to recover. Therefore, his acceptance of treatment will be minimal.

"How am I going to face the physical problems associated with withdrawal?"
"What kind of treatment are they going to give me? – an operation"?
" 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 are recognised and discussed with empathy. Open discussion of the successful recovery of already treated patients and the feedback from those undergoing treatment may foster additional optimism in the patient who has had a history of prior treatment failures, or who is doubtful about the successful treatment outcome.

Focussing on immediate problems

Initially, the patient 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 addiction is his real problem. The most important thing is to show supportive understanding and give him reassurance that his problems will be looked into.

When the professional wants to focus his attention on addiction, she can discuss the obvious physical problems like tremors, loss of appetite, and noticeable weakness. She should concentrate only on the physical problems which are obviously seen. Motivation can be increased by using concrete medical records of the patients if available. Diagnostic tools like blood reports, CT scans, and X-rays with proper explanations from the medical professional will create an awareness in him about the physical damage caused by his chemical dependency.

Identifying motivable areas

Most of the people addicted to drugs have a 'motivable area', which is a sensitive area that has to be identified by the professional. The person may have very warm feelings towards his parents, employer or child. These sensitive areas have to be identified and this can be done by attentive, non - judgmental listening-listening to his verbal and non-verbal communication.

"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 patient to talk about his feelings-the relationships he respects and wants to strengthen.

Assessing motivation

The motivation of a patient can be assessed based on the following factors

- Acceptance of his problem with drugs
- Understanding the damage caused by addiction
- Realizing the need to take an active part in the treatment
- Compliance with the terms laid down by the treatment centre
- Past history of abstinence
- Internal locus of control (a desire to get better for one's own sake).

However, the motivation has to be strengthened and reinforced, which in turn will lead to a commitment to recover. This can be done during treatment through

- Individual counselling
- Group therapy and
- Attendance to AA / NA meetings

Unwilling patients - Help for their families

We have so far discussed techniques for enhancing the motivation of those patients who have already come to the treatment centre. On the other hand, there may be a group of addicted persons who will be unwilling to accept help. In such cases, a family member, usually the wife, or the parent may come to the treatment centre asking for help . What sort of help can be provided for them?

- Encourage them to attend Al-anon meetings
- Provide them with reading materials on addiction
- Help them to attend family therapy sessions
- Help them become aware of their dysfunctional behaviour and make plans to change.

In short, the initial task of motivation is to help the patient accept treatment and it is the task of intervention to bring him to treatment. Further, motivation has to be strengthened at every stage of treatment and worked towards sustaining the gains achieved.

SKILLS SHARPENING TOOLS

VARIOUS STAGES OF CHANGE AND APPROPRIATE MOTIVATIONAL STRATEGIES

Prochaska and Diclemente (1984) talked about five stages of motivation – pre-contemplation, contemplation, preparation, action and maintenance.

PRE-CONTEMPLATION - STAGE 1

The client is not yet considering change or is unwilling or unable to change.

Strategies for the clinician

- Establish rapport and build trust
- Raise doubts or concerns in the client about substance using patterns by

  - ➢ Exploring the nature of events that brought the client to treatment or the results of previous treatments.
  - ➢ Eliciting the client's perception of the problem
  - ➢ Offering factual information about the risks of substance use
  - ➢ Providing feedback about assessment findings
  - ➢ Helping significant others (relatives, friends, employer) intervene
  - ➢ Examining discrepancies between the client's and others' perception of the problem behaviour

- Express concern and keep the door open ensuring support anytime it is solicited

CONTEMPLATION – STAGE 2

The client acknowledges the problem, considers the possibility of change but is ambivalent and uncertain.

Strategies

- **Help the client realise the need for change by**

  - ➢ **Eliciting and weighing pros and cons of substance use and change**
  - ➢ **Examining the client's personal values in relation to change**
  - ➢ **Emphasising the client's responsibility for change**

- Elicit self motivational statements of commitment from the client
- Elicit ideas regarding the client's expectations regarding treatment
- Summarise self motivational statements

PREPARATION – STAGE 3

The client is committed to and planning to make a change in the near future but is still considering what to do.

Strategies

- Clarify the client's own goals and strategies for change
- Offer a list of options for change or treatment
- If willing, offer expertise and advice
- Negotiate a change or treatment – plan in detail
- Help the client enlist family and others' support
- Explore treatment expectancies and the client's role
- Elicit from client what has worked in the past either for him or for others whom he knows
- Assist the client to deal with potential barriers related to entering treatment – finances, leave etc.
- Have the client openly express to family and significant others his plans to change

ACTION-STAGE 4

The client is actively taking steps to change but has not yet reached a stable state.

Strategies

- Reinforce the importance of remaining in treatment
- Support a realistic view of change through small steps
- Acknowledge difficulties experienced by the client in early stages of change
- Help the client identify high risk situations and develop appropriate coping strategies to overcome these.
- Assist the client in finding new reinforcers (new non-drug taking friends, positive relationship with family members) of positive change.

MAINTENANCE – STAGE 5

The client has achieved initial goals such as abstinence and is now working to sustain gains.

Strategies
- Help client to identify alternative methods of enjoyment (games, gardening and rearing pets)
* Acknowlede the client's resolve and support life style change.
- Help the client practice and use new coping strategies to avoid to return to use
- Maintain supportive contact (Self-help group)
- Review long-term goals with client

STAGE I - PRE-CONTEMPLATION – NOT YET CONSIDERING CHANGE OR IS UNWILLING TO CHANGE

Prakash was brought for treatment under pressure by his family members. He met with a scooter accident the previous day under the influence of drugs and had minor injuries. The friend who brought him home was concerned as it was the second accident in two months. Prakash blamed the auto rickshaw driver for the accident.

What strategy would you use to motivate Prakash?

STAGE II– CONTEMPLATION - ACKNOWLEDGES THE PROBLEM, CONSIDERS THE POSSIBILITY OF CHANGE BUT IS AMBIVALENT

Kumar came with his mother for admission to a treatment centre. He wanted to give up alcohol but was ambivalent regarding the decision. While interacting with the counsellor he mentioned that for the sake of his mother he wanted to give up. He was concerned about situations like attending sales conference where alcohol will be served and he was expected to keep company with his colleagues." He said, "Everybody in the sales side drink and most drink more than I do. After working so hard all day, only alcohol helps me relax". He also mentioned few embarrassing incidents which happened at home and at work after heavy drinking sprees. But he was sure that if his friends don't force him, he would be able to abstain from alcohol easily.

Kumar wanted to take off from work for one week, get detoxified and join back.

What strategies would you use to motivate Kumar and deal with his ambivalent attitude?

STAGE III PREPARATION – COMMITTED TO AND PLANNING TO MAKE A CHANGE

Mohan has been abusing brown sugar for the past three years. His friend took treatment in a centre and was staying sober. Hence, Mohan decided to join a treatment programme.

Mohan while talking to the counsellor repeatedly mentioned that he wanted to quit drugs. He said "Once I give up drugs I can easily get a job. Or my parents will provide me money to start a business. I have to give up drugs. That is all I have to do". Mohan had many questions to ask – whether the withdrawal would be made painless with medications ; if he would be 100% fit after taking treatment etc. Mohan was willing to bring his mother and wanted to be treated without his father's knowledge as he would be critical about him.

STAGE IV ACTION - ACTIVELY TAKING STEPS TO CHANGE BUT HAS NOT YET REACHED A STABLE STATE

Ravi was admitted for treatment in a rehabilitation centre. After four days he was physically comfortable. He was feeling great that for the first time he has given up drugs. When his brothers came to visit him at the centre, he repeatedly mentioned

that he will never touch drugs again. He said that he has made up his mind and even if he was discharged immediately, he would stay clean. Even if my friend gives me ten thousand rupees I will not have drugs. He even went to the point of saying "On discharge, I will visit my friends and make them come for treatment. I will be with them, cajole them and make them give up drugs like me". The family members were very happy about his change of mind.

What strategies would you use to help Ravi be realistic about the change he is expected to make?

STAGE V MAINTENANCE – HAS ACHIEVED INITIAL GOALS SUCH AS ABSTINENCE AND IS NOW WORKING TO SUSTAIN GAINS

James had completed his treatment two months ago. His drug using friends no longer called him and he was happy that he was " clean". Evening hours were a little boring. He spent his evenings watching television. He was attending work regularly.

He continued to have a strained relationship with his father and any comment from his father provoked him. James was clear that he should stay away from drugs. He had many issues to deal with - poor interpersonal relationship, no friends and no recreation.

What are the issues to be dealt to sustain the motivation of James?

Strategies.

→ Help the client identify alternative methods of enjoyment (games, gardening, reading etc)

→ Acknowledge the clients resolve and support life style change

→ Help the client practice and use new coping strategies to avoid a return to use

→ Maintain supportive contact (self-help programmes and contact with clinician)

→ Review long term goals with the client.

MH-2c.16

SELF-HELP GROUP – ALCOHOLICS ANONYMOUS

Alcoholics Anonymous'(AA) is a fellowship of people like us who have one thing in common - drinking problem. Our common aim is to stop drinking and to stay stopped. To do this, we regularly meet, talk to and help one another. We help each other to live the AA way of life. This keeps us sober and also shows us the way to help others.

* No qualification is needed to belong to this fellowship - wanting to stop drinking is enough.

* AA meets its expenses by the money given voluntarily by its members.

* Nothing is collected by AA as fees. No one is compelled to pay anything. If one cannot afford to pay, one need not and he is still welcome.

* AA does not run any hospitals, clinics, counselling centres etc.

* AA does not offer financial help. It does not offer jobs. It also does not help any one find a job.

What do we mean by `anonymous'?

Most members of society do not understand the true nature of a drinking problem. They feel alcoholism is a sin or a moral weakness. So they tend to look down on us. This was more so when AA began in the year 1935. Because of this it was decided that those coming for help would be Anonymous. When one approaches AA for help, he

- need not declare his name
- need not give his address
- need not state where he works
- need not disclose his parent's name or any other particulars.

Even if some particulars are given, they will not be revealed to any one outside the fellowship. Thus all members are anonymous. No one outside knows anything about us, individually.

How do we get in touch?

We can get in touch with recovering alcoholics by attending AA meetings which are held in different parts of the city. The list of venues can be obtained from the treatment centre. Those of us who are not in a position to be part of a group, can keep in touch with other alcoholics by writing letters or through telephone. Reading and studying books, periodicals and other literature written by AA members can be of help.

What can a new comer expect at a meeting?

All AA groups have regular meetings. Any one who is interested in alcoholism may attend a meeting. There are no hard and fast rules as to how the meeting should be run. Each group can have its own way of running the meeting. What is most commonly seen is described below.

- Those attending the meeting sit on chairs usually in a circle or in rows.
- The meeting begins with the Serenity prayer being said by everyone. After this, the Twelve steps and Twelve traditions are usually read out.
- The person conducting the meeting will ask one of the members to start speaking. Or he may say that any one is free to speak. Some of these meetings have only two or three speakers who have been decided upon beforehand.
- When a member speaks, he states his first name and then says he is an alcoholic - for example, "My name is Ashok, I'm an Alcoholic."
- The member will speak only about his own experience. He will usually describe how alcohol affected his life, how he got out of it and how his life is today.
- In other cases, he may merely talk about some problem that is troubling him at the moment.
- Since he is disclosing his problems to the group, this is called `SHARING'. The member, as he speaks, talks of his experience, his expectations or his fears. He shares this with the group members as one would with a close friend.
- While some one is sharing, no one interrupts. What is shared is totally confidential. No one talks about it outside.
- When someone has shared his problem, no one gives advice. If one member wants to help another, he will share about a similar problem he had faced at some time in the past, and how he coped with it. These automatically serve as guidelines.
- Towards the end of the meeting, a cover or bag or box is passed around. Each member puts in whatever he would like to contribute. This is usually only a few rupees. This money is used to pay for the refreshments, to pay rent for the place where the meeting is held, etc. No one is under any obligation to pay anything. Usually new comers are not asked to contribute.
- The meeting closes with the Serenity Prayer.

What exactly do we gain by attending meetings?

The benefits are many. The meeting is in many ways the very heart of AA functioning. There are many alcoholics who do not know even how to read or write; but, merely by attending meetings and sharing at meetings have become sober and have changed their lives forever.

Particularly, just after we have stopped drinking, we are confused about a lot of things. Many of us take sometime even to accept the fact that we are alcoholics. We take sometime to understand what we should do about it. It is here that the meeting helps. At the meeting, first of all, we see living proof of the fact that life without alcohol is not only merely possible, but enjoyable and fulfilling. We see so many examples. If we do just two things when we attend the meeting, our lives will change for the better.

I. Sharing

When we share, we must be as honest as we can. It does not matter if one speaks well or badly. What is important is that the truth should be spoken. On certain days we may be happy with what has happened in the office - this can be shared. On other days we may be unhappy at the office - this too, can be shared. Sharing our thoughts and experiences helps in two ways;

- As we share facts about ourselves in front of others, we gradually accept these facts.
- When we are confused about what we should do, just speaking our minds in the group will help us to really understand what the problem is. Our will to act is also strengthened as we share.

II. Listening

We can gain almost as much from listening in the meeting as we do in sharing. When we listen without any intention to criticise, but listen carefully to understand what the speaker is saying, we can learn a lot. Since AA is full of people like us who are trying to lead a life without alcohol, we will find a lot in common. As we listen to a speaker, it is quite possible that some of the problems he has faced would be troubling us also. We can gain a lot of insight into our problems in this way.

The serenity prayer

This is usually said at the beginning and at the end of most AA meetings. It is believed that the entire recovery programme of AA is contained in the prayer.

God Grant us the Serenity
To accept the things we cannot change
Courage to change the things we can
And the wisdom to know the difference

How does this prayer help?

We must first accept the fact that we are alcoholics. There are certain things we can deal with successfully, but there are certain other things which we just cannot change. We cannot use mood altering drugs of any nature because that would bring back the negative attitudes and make the positive sense of self worth disappear. We cannot change the situations or happenings of the past when alcohol was in full control and had taken absolute charge. There is no point in clinging to the past and worrying about things which cannot be changed.

There are several things which we can change. We can correct our past mistakes and make amends to those we had hurt. We can change our attitude towards our family and friends. We can change our resentful attitudes and replace them with tolerance and forgiveness. We can change our entire personality and start practising honesty, humility, appreciation, forgiveness, promptness in admitting wrongs, making amends and rendering service to others. We should not waste our time harping on things which cannot be changed, but rather direct our time and energy in helpful, constructive activities where satisfactory results are possible.

Each worthy thought put into practice brings us a step nearer to the Higher Power. They are the stepping stones which we use to slowly progress to greater awareness of His presence. They are the means by which we make a conscious contact with Him. By constant practice, we can gain the priceless reward of contented sobriety.

The Serenity Prayer, if internalized, and practiced will give us tremendous power and strength to manage our problems to lead a meaningful life.

AA Slogans

There are quite a few AA slogans which if followed, will help us to face life and manage problems without alcohol.

AA Slogans carry a lot of meaning in our alcohol-free life. They are short and easy to remember. They mean different things to different people in different situations. They give a sense of direction - a new way of thinking and acting.

A few of these slogans:

One day at a time

We alcoholics are confused and try to live the whole life at once. We keep worrying about the happenings of the past, and also about what the future holds for us. Our present becomes a sad state, with hardly anything worthwhile done. We usually forget that if we have a kilometer to walk, we must take one step at a time; "I will not drink - come what may, we experience feelings of confidence and the task becomes much easier, if we plan it just for today. I will renew this at the start of the day. If I find it difficult to execute my plan for 24 hours, I will plan just for half-a-day. This can be renewed at the end of 12 hours. If even that is difficult, I can plan for 1 hour .... If that is also threatening, for `just now' - just for this moment.

First things first

For us, to drink is to destroy ourselves. Therefore, staying away from drinks is the first and the most important thing in our life - anytime, anywhere, under any circumstance. The first priority for us is to plan each day properly so that we can stay away from drinking. We can plan to have our daily prayers, attend AA meetings, communicate with the family members, and so on. We put our plans in writing, and execute them systematically, keeping in mind the slogan, "Easy Does it."

Let Go Let God

Many of us continue to feel that we can control our drinking by using our will power. A time has now come when we must let go of such mistaken notions. This slogan enables us to surrender to God after realising our powerlessness over alcohol. When we have total faith in a Higher Power, we find that our struggle gets minimised, and our life takes on a new meaning.

Easy does it

This slogan reminds us that we have not become alcoholics overnight, and therefore, building up sobriety will also take some time. We simply cannot hurry up the procedure. We have to learn patience, acceptance and tolerance.

If you can't go through an obstacle, then go around it.
If you can't solve a problem, accept it.
If you can't finish today, there will be a tomorrow.
Hurry never produced a masterpiece.
Easy does it, but do it!

Live and Let Live

Every one has the right to make his own choices. We have a right to have our own opinions; but at the same time, we also have an obligation to tolerate the opinions of others. We have a right to give expression to our emotions; this automatically implies that we have to tolerate the inadequacies if any, of others. This slogan really helps us to get along with others who may be totally different from us. This guides us to concentrate on our own life instead of getting obsessed with others.

Think...Think...Think

Many of our problems arise because we do not think well before we act. How often we say, "If only I had thought!". To maintain sobriety, instead of rushing into action, we should analyse and think over each and every situation.

And once again, "Think!" because - the habit of thinking makes the difference between thoughtfulness and thoughtlessness; peace and conflict; dryness and sobriety. Think it over.

In short `Alcoholics Anonymous' meetings help us realise that we are not "suffering alone." There are many people around us who experience the same or similar problems. Sharing our problems with fellow sufferers lessens our burdens and also gives us clarity as to how we can manage our problems. They had successfully done it; and therefore, we can also do it - a real hope based on the practical experiences of others.

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INTERNALISING TOOLS

CASELETS

Read each of the case lets and suggest the course of intervention that the counsellor should follow or the issues which have to be dealt in counselling sessions:

1. Joseph was an above average student in his school days. With drug abuse and absenteeism, his academic performance in college had deteriorated. His exams were about 6 months away and he had to clear about 10 papers. Both Joseph and his parents were very confident of his passing the examination.

2. John felt that N.A. meetings were a bore. Every member who came to share in the treatment centre had been as `bad or worse than him', he stated. He did not want to attend N.A. meetings after discharge.

3. Anand is now in his 30's, married with a five year old son. He had lost his mother when he was 2 years old and his father remarried when he was 7. He had a brother, a sister and two step sisters. His relationship with the step sisters was fine. His sister was close to him as well as to the step-mother. But Anand has not even talked to his step-mother for several years. According to him, his step-mother had never discriminated between the children. Yet, he said that he disliked her for the reason that she had taken the place of his mother. Anand's resentment seemed unjustified as the step-mother seemed to really care about him while he was undergoing treatment.

4. It is a month since Ahmed was discharged. To celebrate the new year major music show was to be held in the city. Many of his friends were going and had asked him to join them. Ahmed knew that many in the audience would be using grass. "But it would be fun too. I am wondering what I should do" said Ahmed.

5. Raj has come for his first follow up after treatment. He complained of tiredness and aches and pains in all his joints. He said his appetite had reduced after discharge from the treatment centre. Concentration and memory also seemed to be poor which made him feel anxious.

6. Rajiv appeared to be uncomfortable and hesitantly told the counsellor he had a personal problem to talk about. Slowly, he said he was unhappy about his sexual performance even though it was nearly three months since he gave up drinking.

7. Abdul was jubliant about his recovery. He talked of all the improvements he had made in the six months of sobriety. He had asked his brother for a loan to start a part time business and his brother had agreed. Abdul was happy that with the money from the business as well as his salary he could buy a house quickly.

8. Prem had got his first job which involved marketing home appliances two months ago. Things were fairly okay until the manager expressed displeasure about his sales targets. Prem was upset and wanted to give up his job.

9. Jacob was complaining about his mother. He said she was trying to control him all the time and that they had arguments everyday about - where he went and how he spent his time and money. He said that she had too many expectations and that the situation was unbearable.

10. Rahim was meeting his counsellor after New Year Day. It was ten months after treatment and the first major celebration after discharge. He said that he had a craving but he did not try drugs.

MH-2c.16

T T RANGANATHAN CLINICAL RESEARCH FOUNDATION
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REGIONAL COURSE ON "PREVENTION OF DRUG ABUSE AND ALCOHOLISM" SPONSORED BY NATIONAL INSTITUTE OF SOCIAL DEFENCE, MINISTRY OF WELFARE, GOVERNMENT OF INDIA, NEW DELHI.

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 and 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. Sometimes, it may be 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, nystagmus 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

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metabolites on the brain or an indirect consequence of malnutrition, frequent head injury and liver disease.

Excessive use of psycho active substances be it alcohol, ganja 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, as 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.

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II) Anxiety Disorders – Anxiety is a diffuse, highly unpleasant often vague feeling of apprehension, accompanied by one or more body sensations - eg. an empty feeling in the pit of the stomach, tightness in the chest, pounding heart, perspiration, headache, restlessness etc.

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 the use of cannabis 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 effect 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.

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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 requires prolonged medical help and have to be on anti psychotics under the supervision of a Psychiatrist

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Regional Training Programme on 'Prevention and Management of Addiction"

SPONSORED BY

NATIONAL INSTITUTE OF SOCIAL DEFENCE, MINISTRY OF SOCIAL JUSTICE & EMPOWERMENT, GOVERNMENT OF INDIA, NEW DELHI

PARENTING SKILLS

The problems of children that they face today are created by all of us.
The problem is 'An Adult', never the child itself.

In short-term many schemes of alleviating the condition of children enhancing and enriching the physical quality of their life can be suggested and worked out – But in the long run what will truly help the child is only through

- educating the adult about the needs and problems of the child
- sensitizing them to their responsibility towards children
- strengthening the fabric of family life

Let us understand that

- behind ill-health of the child is ignorance, apathy or indifference of the adult mother, father, care giver or doctor.
- Behind poor education of the child is lethargy, non-commitment of the adult teacher, educational authority.
- Behind child labour is an insensitive exploitative adult and the poverty situation of the parents.
- Behind child exploitation – battering, sexual abuse, drugs. alcoholism etc.
- Behind desertion and deprivation of the child is an irresponsible parent.

In whichever direction of children's problems one turns – there is an adult who like little sponges have the tremendous capacity to absorb the entire gamut of their environment and the values that they grow up with; and as they grow into adults they express what they have sponged in.

Children exist in large numbers in our country.

Some say this over population is a burden.

We must realise it is a reality and that we will have to convert this vast human resource into a strength.

If the process does not start now – we will have on hand, large numbers of children growing up as frustrated youth, lacking vitality and strength of purpose, with untapped potential, expressing aggressiveness in every sphere of their life and action, steeped in uncertainty doubt, hesitation, restlessness. The role of NGO's and their community based programmes must have

- the will to deliver and the strength to resist the temptation to tackle the problems at a superficial and cosmetic level.
- Networking and sharing of ideas, resources, strengths and infrastructure to avoid duplication and optimise service.
- The courage to take up issues and sustain their expressed commitments.

Children

Children are more than the object of their parent's attention and love, they are also a biological and social necessity.

The human species perpetuates itself through children.

Cultural, religious and national groups transmit their values and traditions through children.

Families maintain their lineage through children and

Individuals pass on their genetic and social heritage through children.

The ultimate value of children is the continuity of humanity.

Early childhood is the foundation on which children build their lives. It is not just a preparation for adolescence and adulthood. It is important in itself.

Children develop at different rates and in different ways emotionally, intellectually, morally, socially, physically and spiritually. All are important and each is interwoven with others.

All children have abilities which can (and should) be identified and promoted. What children can do (rather than what they cannot do) is the starting point of their learning.

Young children learn from everything that happens to them and around them; they do not separate their learning into different subjects or disciplines for children, their experience is their learning.

Play and conversation are the main ways by which young children learn about themselves, other people and the world around theme. Children who are encouraged to think for themselves are more likely to act independently.

The relationships which children make with other children and with adults are of central importance in their development.

Parents

Family structure all over the world continues to change in response to industrialization, urbanization, population growth, increasing longevity, and migration. While these changes have created new opportunities they have also disrupted familiar cultural practices and survival patterns that families have developed over the years to cope with their multiple responsibilities. One aspect of life affected by these trends is the inability of the family to provide optimal child rearing environment in the context of widespread changes in the social fabric of families, neighbourhoods and communities.

Adding to this concern is increased recognition of families major influence on young children's social, emotional and cognitive development.

As a consequence of these changes, among all those concerned with the development of children and families, there is an increased demand for high quality, community based childcare services, as a complimentary rather than alternate strategy the direct provision of high quality child care programmes.

Educators have long acknowledged the significant influence of the family on the care and development of the child and the tremendous cultural and familial differences in parent-child patterns of interaction. A major new objective for professional educators would be that they involve themselves in training parents and future parents in family care and child development skills.

Recognition of the family as the child's primary socialising agent has been accompanied by periodic calls for monitoring parental performance and for recommendations for providing parents with child rearing information and guidance.

Any parenting programme must therefore understand that

1. All parents want the best for their children

2. Parents are in a position to be the best observer of their children and consequently, are best able to provide for the physical and psychological needs of their children.

3. Children need to be exposed to certain environmental experiences / interactions for optimal development to take place and an understanding of the principles of child development will help parents to provide these experiences, find methods to enhance learning if they know how to and why they are important.

4. There is no one way to rear children each culture has developed their own methods of parenting. We can enrich our knowledge and expand the life experiences of children by combining the strengths of differing cultures.

5. Child rearing practices are embedded in the culture and grounded in cultural patterns and beliefs and determine / effect style and quality of care giving and to a large extent, the behaviours and expectations surroundings a child's birth and infancy. They also influence childhood, adolescence and the way these children parent as adults.

6. The importance of community involvement is vital in all steps of the process building on what exists already within a community and creating partnerships to help sustain efforts.

Bonding awareness

Right from day one, a bond is being formed between parent and child. Every contact / loss of contact leaves on unbelievably deep impact on the relationship. Few parents seem to know or appreciate just how important they are in the lives of children. How much more a child wants from them emotionally and spiritually rather than the materialism – which the parents are so busy supplying in increasing abundance.

The parents must realise

They are the go – between for their baby /toddler / child and his environment.

They are providers of stimulation to catch his interest;

- of responses to his attempts to communicate; and
- of physical care, so that his skill of attention and concentration develops

they are protectors – who keep him safe and limit his environment so he can feel in control of himself.

They help him achieve what he sets out to do. In all, they are his, first significant persons. It's from them he learns to trust, to get comfort, to communicate and to respond to the world around him.

Children have 3 vital needs

Love / care (or)	Loving and caring relationships can relieve even the most extreme levels of stress
Relationship	Without it, the child's growth cannot be stimulated both physically and mentally A stable relationship gives emotional security
Self-esteem (or)	They must learn to trust themselves and develop a feeling of competence and a desire to try
Sense of self	Learn to accept their failures and short comings and yet have an expectation of success
Communication	- Children communicate well before they talk - We need to listen and watch and demonstrate our interest in their words and messages - Encourage language development and expression - Children need to talk – therefore, we need to give them the opportunities - Children learn to speak by listening to people around

Parent education is a woman's empowerment programme

Mother is the vital baton in passing on the link of family dignity and culture from one generation to the next.

Educating the parents in their irreplaceable role as "mother" and "father" and educating the rest of the family to recognize, appreciate and support them in that role – has become a crying need.

All issues of women's upliftment, be they in the direction of social freedom, economic opportunity, political awareness and / or spiritual awakening, at this point in civilization, need to stress her non-duplicable, non-transferable role as mother.

Women's issues that focus on the inferior /oppressed role in society that the women have today must include motherhood education and counselling initiatives.

Society and family must

- appreciate her significant role in the continuance and enhancement of family life and perpetuation of the future generation as also respect her individual needs as a Human Being.

- Help her through the frustrations of the loss of her freedom and the physical and mental strain of being "on demand" 24 hours.

- Educate her, in pre-natal and post-natal, in child care so that she has the primary care giver can provide the much needed stimulation so vital for the healthy growth and development of the child.

- Support her in her endeavours to care for her child and spend as much time with her child if she is employed.

- Stress the vital role and responsibility of the Father in the social and emotional development of the child rather than his largely prevalent role as economic care giver.

TRUE PARENTING = MOTHERING + FATHERING

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HARM MINIMISATION - TTK EXPERIENCE

INTRODUCTION

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Fundamentally, the consequences of HIV infection are the same in people with a history of injecting drug use as in any of other so called risk groups. There are, however, a few important differences which should be noted down. Kaposi's Sacoma (KS) is much more common in people who have apparently acquired the condition sexually rather than by inoculation. Bacterial infections are generally more common in injecting drug users than other people with HIV infection. This is particularly true of skin infections, bacterial pneumonia and tuberculoses (TB). Abscesses and cellulitis are obviously commonly seen in people who inject drugs. TB is found with increased frequency amongst injecting drug users regardless of their HIV status. The patient with HIV infection is however much more likely to develop clinical manifestations from TB than the sero negative patient.

Incidence of IV drug use & HIV /AIDS in India

In India, heroin addiction is about two decades old and the estimated number of heroin users stands at 3 million. Over the past few years buprenorphine abuse is increasing among heroin users. In Manipur, HIV sero positivity among intravenous drug users shot up from 0%in 1989 to 50% within six months. Now it is around 80%.

In Chennai the ethnic crisis at Srilanka paved the way for increased availability and usage of heroin in 80's. Shortages in mid 80s resulted in the users looking for alternatives. Injecting buprenorphine had become one of the alternatives. Mostly nitrazepam, diazepam, and dextropropoxyphene were abused. In 1991, after the assassination of Rajiv Gandhi by Srilankan terrorists, there was a heavy crackdown on the Srilankan militants living in Tamilnadu resulting in an acute shortage of heroin. Brown sugar users shifted to injecting buprenorphine. Thus, there was a sudden increase in IV drug users.

The city of Chennai is currently estimated to have about 10,000 to 15,000 IDU's mostly located in ten different pockets. Kodambakkam is one of the major pockets. The drug of choice is brown sugar and/or cocktails of pharmaceutical preparations like diazepam, phenaramine maleate, promethazine with buprenorphine. A few are known to inject dextropropoxifine.

The HIV status among IDUs has gone up from 20% in 1999 to about 30% now. The drug users are known to widely share injecting equipment, paraphernalia and also drugs. They are also known to indulge in drinking and high risk sexual activity. Hence, the threat of HIV spreading from the IDU population to the general population looks imminent and dangerous. It is estimated that only 15% of IV drug users get any medical assistance. Their general health, productivity and hence economic status are very much compromised. Criminality has increased mainly to sustain their drug taking habit and hence increased incidence of arrests and convictions.

The current situation of AIDS looming large in the society with about 30% of IVD users being HIV positive and part of the society. It is therefore imperative that we address this alarming situation effectively.

Some of the intervention methods available are – long-term in-patient care with total abstinence as a goal. In other countries, methadone is provided on a day to day basis to prevent the use of drugs. Others take a deterrent approach in which the threat of imprisonment or other penalties are used to motivate behavioural change; and still others use a model of individual education in which information is presented about HIV, AIDS and ways to avoid becoming infected or transmitting the virus to others. The hitherto available models of treatment were unable to address this problem effectively due to high relapse rates and limitation with regard to availability of services.

Obviously, the best way of avoiding the transmission of HIV through injecting drug use is to avoid using illicit drugs, or at least to avoid injecting illicit drugs. This is certainly the traditional approach of the health care services to illicit drug use. It does, however, have to be recognised that many drug users do not wish to discontinue their drug usage and the advent of HIV infection and AIDS has, to some extent, shifted the emphasis of drug usage from abstinence to harm minimization - to reduce and minimize the harm posed by continued drug use.

What is harm minimization

Harm reduction is a new paradigm now emerging in the field of addiction. This strategy recognizes that people always have and always will use drugs and, therefore, attempts to minimize the potential hazards associated with drug use rather than the use itself.

A set of strategies that encourage substance users and service providers to reduce the harm done to drug users, their family members and communities by their licit and illicit drug use. Harm reduction is designed to reduce destructive behaviours associated with drug abuse and related problems. By this approach, attempts are made to reduce

adverse health, social and economic consequences of drug use without necessarily eliminating drug use. Through this approach, some patients achieve stable abstinence after treatment, many reduce consumption and there is over all improvement in functioning i.e. physical health, occupational functioning and psychological state.

The most effective way of getting people to minimize the harmful effects of their drug use is to provide user friendly services which attract them into contact and empower them to change their behaviour toward a suitable intermediate objective. This means services which are easily accessible, confidential, informal, and relevant (focus is not on abstinence, but reducing the harm). Practitioners of harm reduction programme are open minded and have a non judgmental attitude towards alternative methods of reducing the harm caused by IV use.

Some of the harm minimization methods are

- methadone maintenance programme (not available in India)
- providing buprenorphine sublingual tablets
- providing needles and syringes

Harm Minimization Project - Outreach Centre

The goals of the project :

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2. To help the addicts stop usage of street drugs and resort to sublingual use of drugs.

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❖ Minimization of the spread of infections like HIV by altering needle sharing behaviour and teaching safer methods.

❖ Creating awareness about HIV-AIDS.

❖ Helping the addicts resort to a change in behaviour focusing on improving the quality of their lives.

❖ Motivating the drug addicts to get into a "total abstinence" oriented programme over a period of time.

Location and target population

IV drug users living in Kodambakkam area (geographical proximity- within 3 to 5 kms radius)

Principles

- ❖ Treating the user with respect and dignity.
- ❖ Providing services with care, concern and empathy.
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Stipulated behaviour at the centre

- ❖ No physical or verbal violence of any kind on the premises.
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Programme and Activities

- Substitution therapy
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Medical help

- ♠ The medical practitioner makes the diagnosis.
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- ♠ Medicines are given for other infections (of chest, stomach, etc.)
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- ♠ Providing condom/ bleach.

Psychological support

Group therapy sessions

Information, advice and guidance on

- HIV/AIDS, hepatitis, blood borne infections.
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Factors responsible for compliance with programme leading to life style changes

- Clients selected from a nearby community which ensures easy accessibility to services (8.00 a.m. to 7.00 p.m.)
- Choice of services from abstinence to harm reduction
- Availability of buprenorphine which helps in cutting down IV use
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ART THERAPY

Art therapy programme

Art

- Art symbolizes personal, cultural aspects of development
- It predicts trends in a society
- It is personal expression of creative ideas
- Artistic work has aesthetic considerations as prime importance. It gives only satisfaction. It has minimal therapeutic value.

Art therapy

- Person and process is of prime importance
- Individual feelings, thoughts and attitudes matter very much
- The client and therapist relate and the whole dynamic process has therapeutic value

Definition

- Art therapy is a therapeutic procedure using art and other visual media designed to assist favourable change in personality or living that will outlast the session itself

Reasons why art therapy helps

- Visual thinking
- Expressing what words cannot
- Emotional release
- Creating a product
- It is possible for everyone to involve in the therapy
- Art as a way of knowing others

History of art therapy

- The term first used over 40 years ago
- From prisons - drawing with charcoal on walls
- From hospitals- drawing on napkins and other available material
- Practiced now in more than 60 countries around the world

Scope of art therapy

- The drawing once created is a personal record that can be referred over time
- A sequence of drawing can reveal changes in attitudes or relationship over time

- It permits fantasy to create something lost or past. (Return back to relationship to finish unfinished tasks)
- Client can safely represent the frightening ideas and after creation can work his fears
- Possibility of projecting into future and learning to deal with it.

What art therapy is not

- It is not only for people who show interest in art or have natural talent in art
- Art therapists are not art teachers. They should have training in psychological therapies and possibly in art too
- Art therapy is not a form of occupational therapy

Choice of art materials

- Crayons
- Colour pencils
- Water colour
- Sketches, markers
- Poster colours
- Oil colours
- Collage
- Chalks
- Charcoal

Choice of material depends on

- Versatility of the medium
- Type of client
- Stage that has been reached in therapy
- Clients in presenting therapeutic problems

Client groups

- Individuals
- Families
- Specific client groups (chemical dependency, Institutionalized, Terminally ill
- All people of any developmental range: Children, Adolescents, Adults and old people

Techniques
Introduction

- Art therapist is both participant and observer of the process of change
- Before each session, explanation about session and instructions are clearly given about materials, boundaries and settings
- No direct interpretation or analysis of art work allowed
- The client and therapist explore the meaning of drawings
- The client should be helped to share how he feels
- Reflection and clarification of feelings allowed
- The same rules as group therapy apply. Enquiry and questioning as in group therapy allowed
- The therapist can summarize at the end of the session

Few theoritical standpoints

Behaviourist

- Recognition of order and form, acquisition of skill and learning techniques

Freudian

- Spontaneous imagery released from unconscious-other concepts of psychoanalysis apply. Client is brought from 'couch' to the 'easel'

Rogerian

- Relationship between client and therapist is important.
- Boundaries and settings are clearly explained
- No judgement/ praising the work on its aesthetic or technical merit

As used in TTK Hospital

- Art therapy is used as adjunct therapy
- Through art therapy, counsellor accepts and understands patient
- Counsellor is warm, empathic and non-judgemental and genuine.
- Materials, setting and boundaries are clearly explained.
- No criticism or evaluation of work based on technical merit or aesthetic value
- Mirroring, reflecting, questioning, clarification, confronting and bringing insight allowed as and when appropriate in the process of therapy
- Summary of session given at the end
- Counsellors are trained before conducting sessions

Art therapy in groups

Projective art groups

Common frame work to which client relates his personal meaning. Self and group exploration in sharing of a common theme (e.g. house, tree, person)

Group art work

Working together as a group rather than each person offering individual contribution. Working together helps to elucidate interpersonal relationships

Structured art therapy groups

- Includes simple boundary rules and some prescribed activities
- Boundary rule-paint what you like, but use only 3 colours
- Prescribed activities-choose one crayon and have a non-verbal conversation with the other person on the same sheet of paper

Art games

Based on rules which define the frame work of that activity

- Draw an advertisement for yourself
  If outcome is not satisfactory, free to change or add rules by agreement of participants
- Imagine yourself as a owner of a department store and depict your personal qualities

Family art therapy

- Can observe the entire family unit's functioning
- Portrays dynamics of the family unit
- Can understand person's perception of his/her position within it
- Whole family can work together as 'projective art group' or 'group art work'

Art therapy as a tool in diagnostics

Can be used as a tool in assessment/diagnosis

- Neurological conditions
- Psychiatric conditions
- As projective method for testing personality traits/defects

Few web sites

Art therapy on the web

http:/www.sofer.com/arttherapy – (American art therapy association)
http:/www.arttherapy.org – (British Association of Art therapists)
http:/www.baat.co.uk – (Australian National Art Therapy Association)
http:/www.anata.synflux.com.au

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FAMILY THERAPY

The list below summarises the main characteristics of two contrasting models of family life.

Dominator families	Partnership families
Competitive structures	Cooperative structures
Misuse of power	Equitable use of power
No equal rights	Equal rights
Family secrets	Open communication, no secrets
Rigid and compulsive rules	Flexible rules
Rigid gender roles	Flexible gender roles
No sharing of housework	Housework shared equitably
No joint family activities	Planned family activities
Economic "burdens" unshared	Economic responsibility shared
No respect for personal privacy	Respect for personal privacy
Win-lose conflict resolution	Win-win conflict resolution
No shared decision – making	Shared decision – making
No shared parenting	Parenting shared equitably
No support for feelings	All feelings are accepted
Discipline by violence and shame	Discipline based on respect and trust
Mistakes not admitted	Mistakes admitted
No apologies given	Apologies made when needed
Problems blamed on others	Personal responsibility for problems
Resistance to "outsiders"	Openness to outsiders
Loyalty to family based on "duty"	Loyalty to family based on trust
Resistance to change	Openness to change
No family unity	Cohesive family unit
No protection from abusive acts	Members feel safe, protected
Conflicts are ignored	Conflicts are resolved immediately
Little or no laughter or joy	Family is seen as a source of joy
Children unplanned and unwanted	Children planned and wanted

No family has all of the characteristics of either model, however, the characteristics of the dominator model are far more common in families in most countries of the world than those of the partnership model. As long as this is true, it will be difficult or even perhaps impossible to create and sustain democratic societies.

What causes tension in the family

A study conducted by the family life and marriage counselling centre of the New Delhi Branch of the Family Planning Association of India has enumerated the following causes as sources of tension in the families in India.

- Economic or financial problems
- The husband coming home late
- The husband's habits like gambling and alcoholism particularly under conditions of economic hardship
- Suspicion on the character of husband / wife
- The husband not trusting the wife and lying about where he goes and the wife eventually coming to know about it all
- The husband being without a job and being dependent on other members of the family
- Mother-in-law versus daughter-in-law situation. Mother-in-law's indifferent treatment of the daughter-in-law
- Sex differentiation in children born to different daughters-in-law resulting in different treatment of the daughters-in-law the one giving birth to a male child being preferred to the one giving birth to a female child
- Difference in opinion between husband and wife and the in-laws over upbringing of children
- Infertility as a cause of family tension, particularly in families where one daughter-in-law has a child and other does not
- Different treatment to working and non working daughters-in-law. Difference in attitude to working women
- Indifferent or cold treatment to wife's parents and other relations
- Educated children in the family being unemployed
- Property disputes
- Lack of mutual acceptance and understanding

- One earning member and various dependents
- Discrepancy between needs and resources
- Dowry system and related problems
- Lack of proper housing facilities leading to disputes with the neighbours regarding sharing of common resources
- Dominance of one partner over the other
- Attitude towards management of finances and the respective role of the two partners in it

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ABOUT HIV / AIDS

AIDS (Acquired Immuno Deficiency Syndrome) has been described as the "worst plague of the century". Despite intensive research for medical and clinical intervention, there has been little success; a vaccine or cure for AIDS in the foreseeable future seems improbable. Under these circumstances, it is evident that the worldwide spread of this infection can only be controlled by attempting behavioural change through a societal response comprising of awareness and education strategies.

Today a total of 34.3 million people (1999) are estimated to be infected with Human Immuno Deficiency Virus (HIV) the causative agent of AIDS. HIV infection is on the increase all over the world. Everyday about 8000 new HIV infections occur. With at least 3.7 million people in India infected with HIV and with the infection rapidly spreading, health personnel in India need to be well aware of the magnitude of problems associated with the spread of HIV / AIDS .

The diagnosis of HIV is very traumatic and the mental trauma for the patient is often as great (or even greater) than the physical distress. As HIV carries a strong social stigma, there are social issues that are relevant. Due to the massive and well directed prevention campaigns, the spread of HIV-AIDS is slower in the industralised countries. On the other hand, majority of the new infections occur in developing countries like India, Thailand and Indonesia.

What is HIV?

Our body is like a fortress, with a very efficient defence / immune system. The first line of defence is the skin, mucus membrane, tears, ear wax etc. They ward off the surface dangers the body could be exposed to. **If the infective agents get under the surface, the WBC (White Blood Cells) and lymphoid tissues like the tonsils, spleen, lymphatic system etc. attempt to fight it.** If it still persists, then the acquired immunity system takes over. Antibodies are produced to vanquish that particular infection.

The essential ammunition the WBC system contains is the T4 lymphocyte or helper T cell. The T4 cells are produced in the spleen and bone marrow of man during the fetal stage, infancy and childhood. The T4 cells keep circulating in the lymph and blood, during which they pass through the Thymus gland. The gland acts like a computer and programmes the T cells to identify

- self cells belonging to one's own body and
- foreign cells from foreign bacteria, viruses and other germs.

The T 4 cell not only recognises anything foreign but also gives the command to the rest of the immune system to go ahead and attack the foreign organisms. But, unfortunately the Thymus gland stops activity after childhood and the adult body cannot make anymore programmed T4 cells. So the number of programmed T4 cells in our body is limited to 200-300 billion. The T4 cell lives for 60 to 65 years which is why older people after the age of 70 are more prone to infections.

The T4 cell has a projection on its wall into which the HIV agent fits like a key fits into a lock. On impact, the T4 cell unwillingly starts producing viral particles. Thousands of HIV are produced in one T4 cell and the T4 cell bursts, releasing these viruses which then go on to attack other T4 cells. As the number of viruses in a person's body increases, the number of T4 cells decreases, and slowly but surely, the immune system is destroyed.

Where is HIV found?

HIV is present in all body fluids like blood, semen, vaginal fluid, mother's milk, sweat, tears, saliva, urine etc. But only blood, semen, vaginal fluid and mother's milk are implicated in the spread of HIV.

How does HIV spread?

The three routes by which HIV can spread from one person to the other are

1. Infected blood
2. Sexual contact and
3. Infected mother to child

Infected blood

- Blood transfusion of infected blood will definitely result in infecting the recipient. In India, around 10 to 15% cases of infection are the result of infected blood transfusions.

- Use of infected needles, syringes and other skin piercing instruments also pass on the infection from the infected individual to others. Among IV drug abusers, reuse of unsterilised, infected needles and syringes by many people is very common.

Sexual contact (through infected semen and vaginal fluid)

In India 70 to 80% of all HIV infections is through the hetero-sexual route. Though all penetrative sexual activity can lead to infection, the following points are to be noted.

1. If one of the sexual partners has ulcers on the penis or in and around the vagina due to other sexually transmitted diseases (STDs) eg: syphilis, genital herpes or genital warts, the HIV spreads more easily.

2. Anal sex is the riskiest from of penetrative sex because multiple injuries and tears are caused in the anal wall, which makes it easier for the HIV to enter the blood stream of the partner. This is why it spreads fastest among homosexuals.

3. Oral sex-when the mouth is used for penetrative sex, the amount of virus secreted in the saliva is comparatively less, but still there is a certain amount of risk of infection. Similarly there is a very small risk factor associated with deep kissing (french kissing). The risk increases if there are bleeding gums and ulcers/ injuries in the mouth.

From an infected pregnant mother to her child

The HIV passes from the infected mother:

a. during pregnancy through the placenta to the fetus
b. through the mother's breast milk to the baby

30 to 40% of babies born to HIV positive mothers are infected. Experimentally, antiretroviral drugs have been tried in pregnant women with some success in preventing the transmission from mother to child. The mother should be told about the facts and the option of having an abortion can be presented to her.

What happens when a person is exposed to HIV ?

It is important to establish the fact that exposure to the virus may or may not lead to infection. Many factors like the route of infection, the quality and quantity of virus and some as yet unknown factors play a part. But, once infected with HIV, the person carries the virus in his body throughout his life.

There are four stages in the development of the disease:

Stage 1

A healthy person gets infected with HIV. (The infected person remains healthy with no signs of illness for several years.)

Stage 2

This is an asymptomatic stage where no symptoms are noticed. Between six and 12 weeks after infection, the body produces antibodies against the virus. This period lasts from three months to 12 years.

Stage 3

Illness associated with HIV infection may appear. The person may begin to show signs of illness like generalised swelling of the lymph nodes particularly at the back of the neck

and armpits. Other signs such as weight loss, prolonged diarrhoea, unexplained fever lasting more than one month and fungal infection in the mouth appear. Breathlessness, fatigue, night sweats, persistent cough and recurring skin infections may occur.

Stage 4

As the immunity system has totally collapsed he is unable to fight off any infections. So, any opportunistic infections can set in and become life threatening. Some of the common infections are:

Lung infections	- Pneumonia and TB
Gastro	- Intestinal infections - severe diarrhoea Brain infections causing severe head aches, fits and dementia
Cancers	- Skin cancer (Kaposi Sarcoma, non Hodskin's lymphoma and primary lymphoma of the brain)

The end finally comes in the form of death in about 6 months to two years.

WHO Classification

Since sophisticated methods for counting CD4 cells and carrying out blood tests may not be available in many developing countries, WHO has listed a few signs that help in the provisional diagnosis of AIDS in adults. The presence of at least two major signs associated with at least one minor sign can be an indication of AIDS provided other causes of depleted immunity, like malnutrition have been ruled out.

The major and minor signs are listed below:

Major signs

- Weight loss greater than 10% of body weight
- Fever for longer than one month, intermittent or continuous
- Chronic diarrhea for longer than one month, intermittent or constant

Minor signs

- Persistent cough for longer than one month
- General itchy dermatitis (skin irritation)
- Recurrent herpes zoster (shingles)
- Oropharyngeal candidiasis (fungus infection in the mouth / throat)
- Chronic progressive and disseminated herpes simplex infection
- Generalised lymphadenopathy (swelling of lymph glands).

Who are at high risk?

Any person who has

- Multiple sexual partners
- Casual unprotected sex (without using condoms)
- Sex with male or female prostitutes
- Homosexual encounters and
- Intravenous drug users
- Persons who receive blood transfusion with untested blood
- People needing multiple blood transfusions due to haemophilia, thallasaemia, cancer etc.
- Having sexual partners who are one of the above

How one can prevent infection

No drug has been discovered so far to kill the virus as long as it is inside the body. But once outside, the HIV is a very weak, fragile virus which is easily destroyed by:

- Heat through drying or boiling
- Use of chemicals such as acid or household bleach

Prevention of infection through the sexual route by

- Having sex with only one partner who is faithful
- Avoiding pre-marital and extra marital sexual activities
- Avoiding unprotected, casual sex
- Avoiding having sex under the influence of alcohol / drugs when the power of discrimination is likely to be impaired
- Using good quality condoms. This gives considerable protection against not only HIV but also against other sexually transmitted disease like syphilis, gonorrhoea etc.

Prevention of infection through infected blood

- When blood transfusion is required, blood from a voluntary donor/voluntary blood bank, which is tested, and has a label stating that it is ELISA negative, should be used.
- Use disposable or adequately sterilised needles and syringes.
- All skin piercing instruments like knives, scalpels, needles and dental equipment should be sterilised before use. Razors and blades can be sterilised by boiling in water for 20 minutes or keeping them immersed in household bleach for 30 minutes

One cannot get HIV through

- Normal social contact like shaking hands, hugging, sharing plates, cups, glasses, etc.
- Using public toilets, swimming pools, public transport like buses, trains, etc.
- Food, drinks etc.
- Insects, bugs, mosquito bites
- Sneezing, coughing etc.

Play safe

- Practice safer sex. Always insist on the use of condoms, even in the case of oral sex, no matter how embarrassing this may be. Remember this is, quite literally, a matter of life and death.

- Insist on using sterilized equipment when you go in for any invasive procedure; this includes a visit to the dentist and the occasions when you get your ears and nose pierced. Always use disposable needles when you need to take an injection.

- In case you have to have a blood transfusion, make sure that the blood you receive has been screened for AIDS by a reliable blood bank. Or better still, ask such friends and relatives who have the same blood group as you, to donate blood. (Experts from Sunday, September 5-11, 1993).

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CLIENT PROFILING

Addiction treatment centers generally offer a program structure wherein a large part is group based. Through the lecture sessions and other group-based activities, input about general aspects of addiction is provided. The client is able to relate to the program, increasing his insight and strengthening his decision to abstain from drugs and alcohol. Yet, this by itself is not sufficient. Each client enters therapy with a unique set of problems as well as strengths. Client profiling which goes on as part of counseling, ensures that adequate help is provided at the individual level in a way that each client's specific needs are recognized and addressed.

Client profiling can be done at three levels:

- at intake, prior to admission
- during the active phase of treatment
- during the follow-up phase.

The focus at each level is different and aspects covered will also be different.

CLIENT PROFILING DURING INTAKE

As this is the first meeting of the client with the treatment center, it is of crucial importance. While the general progress of the disease and the damage it causes are similar, the individual aspects need to be recognized even at this level.

At the intake level, client profiling is necessary to assess

- the severity of addiction
- the problem areas and identify drug related damage
- his motivational status and factors that influence it.

Purpose

Client profiling at the intake level serves a variety of purposes.

a) Screening clients before admission ensures that only the appropriate kind of clientele enter the program.

For example, a client with a primary psychiatric problem may need in-patient psychiatric treatment rather than addiction treatment. Apart from being unmanageable, his presence can be very unsettling both for the other patients as well as the staff.

b) Client profiling ensures that client-treatment matching is made possible. It helps the professional provide the level of care the client needs to ensure smooth recovery.

A client in the initial stage of abuse may profit from a few out-patient sessions or brief intervention therapy rather than a specialized treatment program.

The client with a long history of abuse, multiple drug abuse, previous unsuccessful treatment efforts and poor family support will possibly profit more from a long-term after care program rather than a fifteen day primary treatment program.

c) On admission, client profiling helps in client-counselor matching. Designating clients to counselors cannot be randomly done without recognizing individual needs.

The complexity of the client's problems, his personality, age, the language he is comfortable with and social background are issues that should be considered. The counselor's level of expertise and style of interaction also need to be taken into consideration.

A 50-year-old villager will probably relate better to a middle-aged counselor who speaks his native language rather than to a 22-year-old who speaks his language with an English accent.

Clients respond differently to different counselors. While some clients may need firmness and active prodding, others need a lot of patience and support to work on issues. Client profiling thus helps the center choose the right kind of counselor for the client.

d) By focusing on individual needs and problems, the client and his family are made to understand the severity of the problem and this ensures their involvement and cooperation.

e) The client is helped to see that the program is related to his own special needs and not a general approach which will see him as just another in the crowd. Profiling thus helps in enhancing the client's motivation.

At intake, the treatment goals and objectives of the program are explained to the client on an individual basis. Based on profiling, the different aspects of treatment can be emphasized to make it more appealing and meaningful to the client. For a client with a marital problem, the family therapy program and marital counseling are probably going to be more meaningful. A client who thinks for himself and wants to know more, is likely to value the lectures and group sessions.

Structure for Intake Session

The following details are collected both from the client and family members:

- basic details of age, sex, occupation, income, marital status
- a brief history with information about the kinds of drugs abused, years of abuse
- Problems related to physical health, family, work, finances and a brief assessment of mental status
- patient's motivation to take help and the influencing factors.

As the focus of the session is to quickly assess the client and highlight the need for treatment, the issues are not discussed in detail at this level. For instance, it may be just sufficient to know that a significant amount of debt exists without details of where and when the loan was procured.

This structure is of course only an outline and it calls for flexibility from the counselor to take the client and the family through this. When intake profiling is carried out with sensitivity and professionalism, it goes a long way in enhancing the quality of treatment.

CLIENT PROFILING DURING TREATMENT

During treatment, information about the past as well as the present is required. The past is discussed not to trace the cause of addiction but rather to understand the factors that influenced him. The past events may be unchangeable, but is necessary to understand the client's present situation in relation to the past.

While discussing the present situation, two aspects need to be considered:

- The variety and intensity of problems the client faces. The problems need to be identified and assessed to develop an appropriate strategy.

- The resources available to meet the problems. His personality strengths and skills are the internal resources he can draw on. Support from his family and friends both at the material and emotional level are external sources of support available.

During the treatment program client profiling is done in a more detailed and comprehensive manner than at the intake. Flexibility and patience are often called for as the client may provide details in bits and pieces rather than in a focused manner. Each area of life is discussed in isolation and gradually the fragmented pieces of information are put together to understand the client in totality. Family's involvement is necessary as details are most often forgotten or suppressed by the client either by design or by oversight.

Structured formats are generally used to make effective client profiling.

The following is an analysis of how information collected can be made use of towards client profiling.

FAMILY HISTORY

Details of Family Constellation

Details of client's brothers and sisters, their age, education, present occupation and other details can help the counselor understand his position in the family.

Only male child or the birth order (the eldest or the youngest) or a vast age difference are factors that can influence the manner in which he is viewed by significant others.

When the client's education or income is much more or much less than the other siblings, it is important to think about what made him achieve more or less than the family norm. This helps to reconstruct the past and understand his position in the family system – the position assigned to him, the power he enjoyed and the role he played.

Details of Parents

Details about early parental loss or absence of one parent (due to work, illness or poor involvement) can help one understand the lack of emotional nurturing he experienced as a child.

Family routines followed, the disciplining process, the emotional ties with family members as well as the socioeconomic environment at home help one assess the level to which his needs were recognized and fulfilled during childhood.

Details regarding the family history of addiction, especially of parents, are important due to the deprivation it brings on all fronts. Alcohol / drug intake may be seen as an accepted norm. Poor work ethics, financial mismanagement and inappropriate ways of handling feelings may be seen as acceptable behavior patterns.

Being witness to or a victim of physical violence can add further trauma as well as lead the child to perpetuate the violence in his adulthood.

CHILDHOOD AND ADOLESCENCE HISTORY

Presence of behavior problems like rebellion or unwillingness to conform during the early years can point to poor limit setting. It can also alert one to underlying psychiatric problems – mood disorders or even an anti-social personality disorder.

Adjustment at school, relationship with peers, academic performance, interest in games and other activities are details that enable an assessment of his interests and skills.

Information about performance at school (dropping out, poor or excellence), handling of money and time, the goals he visualized for his future, the issues that he considered as helpful or detrimental to his growth are important to understand his personality development. His perception of problems (real, imagined or exaggerated) and his response to them will reveal a lot about his personality.

Social skills development, problem solving skills, need for achievement, a sense of self-worth, are all well established by adolescence. Events in his adult life may build or alter this basic structure. In such a situation, recognizing significant events / people who made this shift is again of importance as the negative aspects fuel the damage caused by addiction.

The interpersonal skills and the family ties he developed as an adolescent can point to the support he enjoys as an adult. Even if addiction in the intermittent years has eroded his support base, the relationship can be revitalized if it was strong in the pre-morbid years. On the other hand, conflict ridden or withdrawn style of functioning further aggravated by addiction, point to the need for social skills training during treatment.

ALCOHOL / DRUG USE HISTORY

Information about the age of first use and the perceived need to do so, helps one understand the process of initiation into drug / alcohol intake. While for some drugs are a promise of good times, for others they are a crutch to handle negative feelings.

Details of the gradually increasing quantity and frequency of drug / alcohol intake help one trace the progression of the disease. The client's perception of his drug use is different at different stages of his disease. From a pleasurable activity it would have become a stress-relieving act. Later, he may see it as something that has to be just endured. This helps the client to understand his gradual loss of control over drug use and the severity of his addiction.

It is necessary to identify the factors that propelled or sanctioned the continuing abuse and events or people who cautioned against it. These very forces will continue to influence his recovery and thus need to be addressed.

The client's previous efforts at abstinence either through his own efforts or treatment have to be taken into consideration. The events that motivated, as well as the relapse triggers, can be identified.

Occupational History

Details of jobs held, reasons for the choice or change of jobs and the satisfaction gained out of each, provide important and necessary information.

Absenteeism, poor job performance, poor interpersonal relationships with colleagues and supervisors, impulsiveness or even inability to meet standards expected, could have been the causes of problems on the job. The link between his addiction and job problems needs to be understood. Work ethics also need to be discussed to help him change.

In the post-treatment period the client may suffer from memory problems, poor judgment, and new learning can be difficult. This needs to be worked on and supportive measures need to be planned. Postponing major life changes is important.

Clients may not have any marketable vocational skill to find a job. Vocational training may be called for. Recognition of skills / interests is also part of profiling. This can fuel his ambition to train himself further and improve his job prospects. For example, a college dropout may join a correspondence course so that the lack of a formal degree will no longer block his career prospects.

Marital History

Factors that influenced his choice of spouse, the extent to which his expectations were fulfilled and the strength of the relationship need to be discussed.

Understanding his spouse's perception and reaction to his addiction will help in assessment of the support he will receive during recovery. A passive, enabling spouse may fail to be firm enough, while a domineering spouse may be too controlling.

Information about the separation (where applicable) – the duration, the events that led to it and the reason for getting back – help one understand the dynamics involved.

The presence of violence can point to an aggressive personality style or even an underlying psychiatric problem. Paranoia can further damage the marital relationship. If aggression or paranoia is present only when he is actively drinking or abusing drugs and not otherwise, this is seen as drug / alcohol induced effect. If it persists otherwise too, medication may be needed. He also needs to learn new ways to cope with his feelings and strengthen his self-esteem, so that he can alter the violence cycle.

His relationship with his children and the aspirations he nurses for them can be used positively for his recovery.

Divorce or desertion leaves behind grief and unexpressed anger. Providing a supportive setting to discuss this is important.

If he is still single, it is necessary to discuss his long-term plans. It would be advisable to postpone any plans for marriage until a year after recovery.

Sexual History

Sexual problems need to be discussed. While alcohol / drug induced damage can cause them, the anxieties and myths surrounding them compound the problem.
Pre- and extra-marital relationships can complicate recovery. If a client has entered into such a relationship due to poor judgment and now expresses doubts about the need to continue with it, a plan of action has to be made to break out of it.

When an excessive sexual urge and inappropriate ways of expression are reported, a psychiatric assessment needs to be made.

High-risk sexual behavior like multiple partners calls for some input about HIV-AIDS and testing with due counseling.

Financial Status

Discussing details about his income, the manner in which money is spent, will help in altering impulsive and grandiose style of handling money. The amount of loans he has, the source, the rate of interest he pays – these are some of the details needed to make a financial management plan. Budgeting, prioritizing, making monthly payments for loans / savings are part of the treatment plan.

LEGAL HISTORY

The client's record of arrests and his legal status have to be looked into. Court appearances called for long after the offence can be stressful during recovery. Accidents due to driving under the influence, street fights or arrests due to anti-social behavior can be used to help client understand drug-induced behavior.

SOCIAL RELATIONSHIPS / LEISURE ACTIVITIES

Loneliness and social withdrawal have to be replaced through meaningful changes. Otherwise the empty space created when the client quits drugs / alcohol will make life very difficult for him. Participation in leisure activities and maintaining good social relationships are crucial to recovery.

Revisiting the pre-addiction days and identifying activities, hobbies, people whose company he enjoyed and attempting to revive those interests and relationships are an essential part of his recovery. Making amends, even if it is a simple call, letter or a short visit, may be necessary to review relationships. Handling anxieties and fears related to relationships is part of therapy.

RELIGION

Faith in a higher power can be a very supportive source during recovery. Prayer routines, visits to places of worship or some faith in the concept of a higher power, even if it is not actively pursued, can be used to strengthen his recovery.

Blaming the higher power for all his problems without accepting self-responsibility or a passive 'He will take care of everything' attitude needs to be altered.

PERSONALITY TRAITS

Assessing his personality strengths and deficits is an important part of patient profiling. Addiction brings with it low self-esteem and his strengths can provide a strong support base for his recovery. Helping him see his positive side (skill as a workman or the care he shows for his children) enables him look at himself in a positive manner.

Poor frustration tolerance can show up as irritable behavior at home, frequent job changes on the employment front, and unnecessary expenditure. Helping the client see these links is important.

CLNT PROFILING DURING FOLLOW-UP

Based on the individualized treatment plan, recovery goals and activities are listed. The plan of action is specifically stated for each area. During follow-up, the recovery made or problems encountered are discussed. At regular periods, the client is assessed for whole person recovery indicators – alcohol / drug free life, gainful employment, improved physical health, improved family relationship and crime-free lifestyle.

Conclusion

At every stage of treatment, help is needed at the individual level. Client profiling helps in identifying each individual's unique strengths and addressing his specific problems.

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Regional Training Programme on `Prevention and Management of Addiction"

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COMMUNITY APPROACH OF TREATMENT & PREVENTION

A group of people

Live in a specific geographical location

Relate to each other
Share a sense of belonging.

Community Based Rehabilitation

Persons with disabilities are helped to develop themselves to their full potential within their own community

Making use of local resources
Achieving maximum integration into their families / communities

Primary Focus

Shift the intervention from costly, specialised institutions to the homes and communities of the persons.

Advantages of community involvement

Their feeling of oneness constructively utilised

Responsibility of managing alcohol problem shared between the professionals and the community, leading to `doing with' rather than 'doing for'.

Community understands the processes of alcoholism and recovery. Hence is empathetic and willing to support treated patients in recovery.

Key issues in organising camp programmes

Identifying substance users living in one specific area through multiple entry points

Teachers
Health workers
Clergymen
Animators
Relatives

Initiating the process of rehabilitation before the camp

Home detoxification
Dealing with medical problems
Motivating the client and the family to attend the camp programme

Involving a host organization

Requirements of the host organization

Enjoys the trust and respect of the community
Willing to provide the basic infrastructure to run the camp
Willing to provide support to the patients during the follow-up period

Prior to the camp

To identify and motivate patients for treatment
To provide accommodation

During the camp

To organise meals for the patients and staff
To mobilise support persons for patients

After the camp

To act as support persons for patients
To get patients for monthly follow-up
To monitor the progress of patients
To provide help when there is a need

Empowering the community

Making use of relatives and friends to support the patients in recovery

Maintaining the momentum

Organising regular follow-up programmes
Organising celebration of sobriety birthdays to encourage their efforts
Conducting awareness programmes in the community

Key Findings

With minimal infrastructure quality care can be provided in villages at low cost
Help is available at their doorstep, hence people are willing to accept help
Therapy and treatment procedures are made relevant even to the illiterate villagers, hence appealing
Disulfiram acts as a powerful support
The entire community gets involved in the process

Prevention Activities in India

Gadchiroli in Maharashtra

Data on impact of alcoholism collected
Collective realisation of a common problem
Common will and organisation to act
Formation of 'Darumukti Sangathana' to create awareness on alcoholism mainly by women

Benefits

Alcohol consumption dramatically reduced in 200 villages
Drawn the attention of public and the government and acknowledged as a public health problem.

Dubagunta -- Andhra Pradesh

Women and children joined together
Resulted in imposition of prohibition for a few months.

Chittoor – Kerala

Priests and nuns were forerunners
Churches took up this issue in Sunday mass
Widows of Vypeen tragedy expressed their solidarity
150 days of agitation - women picketed the shops
Manmathan, a well known Malayalam writer supported the movement

In Pather Village in Saharanpur in Utter Pradesh

3 months round the clock 'dharna' by women

Benefit

Liquor shop was permanently closed

In Naktara Chauraha in Raisen District in Madhya Pradesh

3 day hunger strike by woman

Benefits

The sole shop was shifted to the outskirts of the village
Anti liquor movement spread to other villages -- Bansoj, Nara, Barchha, Digari and Shindi

Some of the salient features of community approach

Women (the victims of alcoholism) spearhead the movement

Mainly the villages have taken up the initiatives rather than cities and the towns

No big organisation / no political parties lead this programme, it is a programme of ordinary women.

The methods used are 'dharna', hunger strike and group activities.

The women have also asked for other control measures like shifting the shop to the outskirts of the village or reducing the number of outlets

Successful implementation of the programme in one village has a snowballing effect – spreading the movement to the neighbouring villages as well.

The role of non-governmental agencies

The non-governmental agencies can play an active role in

helping the villagers to organise rallies and dharnas

organising repeated awareness programmes on the ill effects of alcohol and drugs during festival times.

creating visibility to the programme by publishing articles in local newspapers and broadcasting programmes in radio.

making the people talk about the problems and solutions whenever there is a death in the community due to alcohol abuse

making use of community resources like physicians, recovering addicts, local leaders to organise treatment camps on a periodic basis.

mobilising the support of patients who have given up alcohol and the youngsters who do not take alcohol.

providing alternative means of livelihood for illicit brewers.

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RECORD KEEPING

Record keeping has been defined as a written authenticated compilation of those events and processes that describe and document the assessment and treatment of the client.

Record keeping and reporting mechanisms or procedures are usually established and developed in treatment centers. The areas to be covered in the treatment records are – the persons to make entries, the time when they are to be made, the review processes and mechanisms for their safe keeping; these are specified at the outset.

Records in a treatment center for addiction are maintained by the detoxification / medical unit, the intake counselor, the client's counselor and the group counselor. Referrals to after care programs, vocational training etc. are also recorded. Hence, the entire treatment center has a role in maintaining records at various phases of the client's treatment program.

THE PURPOSE OF RECORD KEEPING

- To formulate individual treatment plan: The counselor in a treatment center tailors a plan for each client individually depending on the nature of his specific problem. The data collected from the initial phase to the follow-up phase of treatment are recorded by her in the prescribed format followed by the center.

- To provide continuity of service: The case record serves as a permanent document in the process of the client's treatment at the center. In case the counselor is not available or has left the organization, the new staff can continue to follow up and help the client with recovery using the case recording as a reference.

- To evaluate and review periodically the work of the treatment center: The case recording will serve as an important method of evaluating the treatment center's work and the ultimate objective of the center. The relapse rate of the clients, the quality of counseling, the efficacy of the intervention techniques etc. can be reviewed in the long run. The quality of the treatment by the center can be assessed through systematic maintenance of records.

- To provide valuable resource for research: Case recording is a rich source of data for research. The documented data provides enough material to help the center to examine effective and ineffective intervention, towards a more scientific approach in addiction treatment.

TYPES OF RECORD KEEPING

There are two types of maintenance of individual case records – process and summary record keeping. In process recording, all details including verbal and non-verbal communication are recorded by the counselor immediately after the session with the client. In summary recording, brief and pertinent points are recorded and described subject-wise.

Summary recording	Process recording
Collected information is summarized and brief, with significant parts in detail	Entire information about the client is listed
Focus is on the client with counselor's observation of the client	Both sides of the session are given in detail
Information is not presented in chronological order	Information presented in chronological order under specific areas
Describes the outcome, not the steps to accomplish the results	Steps are explained in detail; includes verbal and non-verbal cues
Less time consuming	Time consuming

Counselors at treatment centers usually use summary recording as an important reference in the management of the client. A copy of the summary recording is filed and made accessible to her when the client visits the center during follow up. The summary recording highlights both short-term and long-term plans of the client and significant information to be worked on, and is crucial in the recovery of the addict.

FACTORS TO BE ENSURED WHILE RECORDING

- Uniformity in recording: The staff should be trained in recording; as a result uniform record writing methods are used.

- Readable and visible: Often, the information given in the case records are not written legibly and may not highlight the crucial areas to be worked on. The records should ensure the visibility of significant information for appropriate intervention by the relevant professional.

- Description of events, not evaluation: During the collection of information, the counselor must ensure that she is merely recording information as it is and not make any premature evaluation which may be judgmental during the process of recording. The staff should ensure clarity, accuracy and objectivity.

- No ambiguity or vagueness: The counselor must record information in a clear and concise fashion. If there are gaps in collecting information about the client's history it should be clearly stated.

- Updated and complete: As far as possible the treatment center should ensure that the records of the client are updated and accurate. Though agreed upon in principle, due to reasons such as pressure of workload, the treatment staff may fail to do this. But it should be remembered that the records are the only backbone of reference to ensure that the treatment goals of the client are met and their completeness is mandatory.

- Confidentiality of clients' case records should be ensured with a separate room or cabinet for storing. Clients' records should not be left unsupervised e.g. on tables, cabinets, etc. There should be adequate security to prevent loss, defacement and unauthorized use of records.

OVERCOMING PROBLEMS IN RECORD KEEPING

Information collected should not only be useful but actually used. There may be too much information which may not be totally relevant to the treatment intervention. The treatment center needs to periodically review the record keeping systems to prevent this.

Often counselors have clients coming for follow up after a long gap and to prevent their facing difficulties in accessing data during such time, the case records should be readily available and accessible to the counseling staff.

Case records of patients can occupy a lot of space leading to storage problems. Old case files of clients usually gather dust, lie moth-eaten and occupy valuable space. As the clients' case records have to be preserved for a long time, taking into account the phenomenon of relapse in the field of addiction, suitable methods of storage of data including computerization of records should be given priority.

Improper maintenance of records is due to many factors. Untrained counselors who lack record-keeping skills; those who lack an understanding of the importance of recording; lack of time; lack of proper facilities (privacy or space) are some of them. The importance of record keeping has to be emphasized, since adequate data is essential to back their successful intervention efforts.

THE ROLE OF RECORDS

THE ROLE OF RECORDS IN PATIENT EVALUATION

The individual case record includes a treatment plan outlining the goals and objectives for the client during treatment. They should take into account the physical, social, educational, vocational, and psychological needs of each patient. This helps in assessment of client's progress; need for modification of treatment plan and the need for referral.

The case record, upon termination of the treatment with the patient, includes a discharge summary in which a final evaluation regarding the progress of the patient towards the goals and objectives set forth in the initial treatment plan and the short and long term goals are recorded.

THE ROLE OF RECORDS IN PROGRAM EVALUATION

The data collected as part of the required record keeping and reporting activities is useful in ongoing program evaluation towards ensuring quality service. This entails analysis of overall program effectiveness and identification of areas needing refinement. Data such as the number of clients served, types of services provided, client outcome, follow-up outcome, and staff utilization etc. can be evaluated based on the records maintained by the organization.

BENEFITS FOR THE COUNSELOR

Proper record keeping presents a complete profile of the client in a precise and clear form; it helps the counselor to render effective and systematic service to the clients; it facilitates the evaluation of the client's progress and setbacks before and after availing the medical and counseling services; and it ensures continuity of work.

BENEFITS FOR THE TREATMENT CENTER

Record keeping helps in the periodic review of data at any point of time; facilitates supervision and training of the staff; improves the professional skills and techniques of the counselors and others; evaluates the work of the agency and helps to improve upon the methods and techniques used therein; and indicates the efficacy of the agency to donor organizations, board of trustees and the community at large.

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WHOLE PERSON RECOVERY

'Whole person recovery' involves improving the various areas of one's life – that is, to recover physically, psychologically, socially and spiritually. This will result in qualitative sobriety. Qualitative sobriety is, giving up chemicals and making qualitative lifestyle changes.

What do we associate the word 'life' with? Life means activity – a series of actions or experiences. Each experience becomes a unit of life just as a brick is the unit of a wall. The strength or weakness of the wall depends on the quality of bricks. Similarly the types of experiences a person undergoes determine the quality of his life.

Here are a few tips for qualitative, wholistic recovery for recovering patients.

1. My life should have a goal

Recovery is a journey. In this journey, only when we have a clear destination, we can choose the right path. In a goal-oriented life, there will be a sense of direction - where to start and how to reach my destination. The goals could be short-term as well as long-term.

The goal can be anything - saving money for the son's education, getting the daughter married, getting a job.

e.g. Vasu was working in an Insurance company. In spite of holding a good job, he has put his son in a free school, as he had no money to pay for the school fees. After treatment, he set a goal for himself.

"I' am going to give the best education to my son." He saved money and everyday he took his son to the tuition class at 6.00 a.m. and guided him to get into the engineering college.

e.g. We treated a patient in a camp at Manjakkudi. Under the influence of alcohol, he used to be violent towards his family members. On one occasion, in a drunken mood, he set fire to the hay stack which was kept outside the house. The entire village tried to prevent him from setting fire. He fought with everyone. The next day, the community

leader called him and asked him to leave the village and stay on the outskirts. After this incident, he sought help in the camp which was being conducted in his neighbouring village. It was during the camp, that he realised his mistake. He set a goal for himself – `I should get back to the village and gain the acceptance of the villagers'. He worked towards achieving his goal.

Now he has completed 5 years of sobriety. He is living happily in his village. In each camp, he is bringing 3 or 4 patients from his village. In the recent election, he was elected to the Panchayat Board.

e.g. An eagle's egg got caught among the eggs of a hen. It was hatched and an eaglet was born. It grew with other chicken. One day, the eaglet noticed an eagle flying high in the sky. It was impressed and wanted to fly high. When he asked the hen, the hen told him, `We are different, we cannot fly high'. The eagle accepted this and decided not to attempt to fly higher than the chicken.

What does the story convey?

All of us are born to win. Sometimes we programme ourselves to disaster / failure.

Nothing will happen by itself. We have to make it happen. A goal-directed life is a growth oriented life.

2. My daily activities should be related to my goal

Just having a goal in life is not sufficient. It is very important to make conscious efforts on a day to day basis to work towards the goal.

e.g. If my goal is to save money, I should stop travelling by auto and adopt cheaper mode of transport. If I am keen on strengthening relationship with my son, I should be prepared to spend more time with him.

e.g.-P T Usha - four hours of exercise both in the morning and evening; and strict diet, she achieved success only through committed efforts and hard work.

3. I should do my work with interest and involvement

Any activity will become enjoyable provided we are interested and involved.

e.g. Three men were involved in building a temple. A man asked the first worker, `What are you doing?' He replied, ' Can't you see what I am doing? I am breaking

stones. It is my fate and I slog on!'. The second worker said, `I have to take care of my family. Since I have to earn for my family, I am doing this boring work'. The third man was very enthusiastic and he said, `I am fortunate because I have got the opportunity to build a temple for my Lord'. Same work, but each one had a different perception.

Whatever we do, when we do it with gusto and enthusiasm, the entire process becomes enjoyable.

e.g. Cleaning the house for Pongal; Making food for guests.

4. I should act according to my conviction

Once I make the decision to give up drinking, it is very important that I stand by my conviction. People may mock, criticise or laugh at me. Relatives may not trust me.

e.g. My friends may tease me `Don't you have will power? Are you afraid of your wife? Is that why you have given up alcohol?'

Whatever be the external environment, I have to decide and go steady on my decision.

5. I should take responsibility for my growth

In my life I have various roles and responsibilities and I am entirely responsible for my growth and development.

e.g. 'I wanted to be on time for my work, but my wife never woke me up.' 'I really did not want to drink, but my wife forgot to give Esperal, that is why I drank.' Here, I am not taking responsibility for my actions, I am holding others responsible.

I should take up responsibilities and also hold myself responsible for the consequences of my actions.

6. Overcome handicaps and limitations

During the course of our life's journey, we may have to face some hurdles like a steep slope, a peak, small and huge boulders, and so on. These can be overcome, provided we are willing to put in effort. We may be required to make a few sacrifices. But once we achieve our goal, all these will add on to our sense of fulfillment.

Louis Braille

He was blind from the age of three and in 1818 he went as a foundling to the National Institute for the Young Blind in Paris. Soon showing marked ability in both science and music, he became famous. In 1828, Braille began teaching the blind in the institute and the following year, he conceived the idea of modifying the Barbier "point writing" system, used for coded army messages, to enable the blind to read. Point writing consists of embossed dots and dashes on cardboard ; the Braille system derived from it, is used successfully today in a slightly modified form in many countries.

Helen Keller

When nineteen months old, she was stricken with an acute illness that left her deaf and blind. No method could be found to educate her until the age of seven, when she began her special education in reading and writing at the Perkins' Institute for the Blind. She quickly learned to read by the Braille system, and write by means of a specially constructed typewriter. Ten years later, she was able to enter Radcliffe College from which she graduated with honours in 1904. Keller then served on the Massachusetts Commission for the Blind. Throughout her life, she worked and raised funds for the American Foundation for the Blind and traveled and lectured in many countries. She visited wounded veterans in American hospitals and lectured in Europe on behalf of the physically handicapped.

Milton was a great poet who wrote the epic Paradise Lost when he was blind.

Demosthenes who was a Greek Orator, had a speech impairment when he was young. He practiced regularly with pebbles in his mouth and became an outstanding orator.

Wilma Rudolf was a polio victim. By sheer determination, she won a medal in Olympics.

Sonal Mansingh

An accomplished Oddisi dancer, she suffered multiple fractures in a road accident, during the spring of her career. Senior surgeons and consultants attending on her ruled out the possibility of her being able to walk, much less dance again. But she would not let the doctors decide her fate. She endured years of painful physiotherapy, and by sheer grit, determination and hard work regained strength in her legs. Today she is one of the best known Oddisi dancers.

Sudha Chandran

Almost the same history as Sonal Mansingh, only difference being Sudha is a Bharathanatyam exponent

God has given us the freedom to choose and inner strength to overcome handicaps and limitations. It is unwise to blame the past, parents or say it was my fate.

MH-2c.31

REGIONAL TRAINING PROGRAMME ON 'PREVENTION AND MANAGEMENT OF DRUG ABUSE AND HIV-AIDS"

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ISSUES IN PRE AND POST TEST COUNSELLING

What is HIV counselling?

HIV / AIDS counselling is an ongoing dialogue and relationship between patient and counsellor with the aims of

1) preventing transmission of HIV infection and
2) providing psychosocial support to those already infected.

In order to achieve these objectives, counselling seeks to help infected people make decisions about their lives, boost their self confidence and improve family and community relationships and quality of life. HIV / AIDS counselling also provides support to the families and loved ones of infected people , so that they in turn can provide encouragement and care for those with HIV infection.

Pre test counselling

Counselling before the test should provide individuals who are considering being tested, with information on the technical aspects of screening and the possible personal, medical, social, psychological, and legal implications of being diagnosed as either HIV-positive or HIV-negative. The information should be given in a manner that is easy to understand and should be up to date. Testing should be discussed as a positive act that is linked to changes in risk behaviour.

A decision to be tested should be an informed decision. Informed consent implies awareness of the possible implications of a test result. In some countries, the law requires explicit informed consent before testing can take place; in others, implicit consent is assumed whenever people seek health care. There must be a clear understanding of the policy on consent in every instance, and anyone considering being tested should understand the limits and potential consequences of testing.

Testing for HIV infection should be organised in a way that minimizes the possibility of the disclosure of information or of discrimination. In screening, the rights of the individual must also be recognized and respected. Counselling should actively endorse and encourage those rights, both for those being tested and for those with access to the records and results. Confidentiality
should be ensured in every instance.

Issues in pre-test counselling

Pre-test counselling should focus on two main topics.

1) The client's personal history and risk of being or having been exposed to HIV
2) Assessment of the client's understanding of HIV/AIDS and previous experience in dealing with crisis situations.

Assessment of risk

In assessing the likelihood that the person has been exposed to HIV, the following aspects of his or her life since about 1980 should be taken into account:

- Frequency and type of sexual behaviour; specific sexual practices, in particular, high-risk practices such as vaginal and anal intercourse without use of condoms, unprotected sexual relations with sex workers

- Being part of a group with known high prevalence of HIV infection or with known high-risk life-styles, for example, users of intravenous drugs, male and female sex workers and their clients, prisoners and homosexual and bisexual men.

- Having received a blood transfusion, organ transplant, or blood or blood products.

- Having been exposed to possibly non sterile invasive procedures, such as tattooing and scarification.

Assessment of psychosocial factors and knowledge

The following questions should be asked in assessing the need for HIV testing:

- Why is the test being requested?
- What particular behaviour or symptoms are of concern to the client?
- What does the client know about the test and its uses?
- Has the client considered what to do or how he/she would react if the result is positive, or if it is negative?
- What are the client's beliefs and knowledge about HIV transmission and its relationship to risk behaviour?
- Who could provide (and is currently providing) emotional and social support (family, friends, others)?
- Has the client sought testing before and, if so, when, from whom, for what reason and with what result?

MH-2c.32

CERTIFICATE COURSE ON COUNSELLING & REHABILITATION OF SUBSTANCE ABUSERS

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Organised by T T Ranganathan Clinical Research Foundation, Chennai 600 020

IMPACT OF ALCOHOLISM

DR. MOHAN ISSAC

* Mortality
* Morbidity
* Disability - `DALY', QALY'
* Effects on Family', Industry
* Costs of alcoholism

MORTALITY

- Premature deaths
- Cirrhosis of liver
- Strokes, other disorders
- Road – traffic accidents
- Suicide
- Homicides

MORBIDITY

- Various alcohol related physical disorders
- Psychiatric disorders associated with alcohol
- Cognitive impairment, other neurological disorders
- Morbidity following R.T.A.

DIABILITY

DALY - `Diability Adjusted Life Years'

- Global burden of diseases

Alcoholism – one out of ten
Most disabling and burdensome disorders

HOSPITAL ADMISSIONS (for alcohol related problems)

✡ Psychiatric Hospitals

- Growing proportion of admissions for alcoholism

E.g. **Institute of Mental Health, Madras**

1953 – 1965	No patients with alcoholism
1966 – 1981	Percentage of admissions for alcohol problems - 0.1 to 3
1996 – 1997	More than 25%

(Somasundaram, 1985, Palaniappan & Soundararajan, 1994)

NIMHANS

1980	Less than 2%
1995	About 25%

Private psychiatric practice

1977	Alcohol dependence constituted only 1% of private practice (Bagadia, 1977).
1988	32% clientele made up of people with alcohol problems (Gopalakrishna & Sayee kumar, 1988)

- More than 75% of GPs treat alcohol abusers with a variety of health and family / social problems (Verma & Malhotora, 1988).
- 15% of in-patients in General Hospitals have drinking related problems (Babu & Sengupta 1997).
- More than 10% of male PHC attenders
  - moderate to heavy drinkers (Moily, 1992)

IMPACT OF ALCOHOLISM

- **Effects on family**
  - Family disruption
  - Domestic violence 'Wife-beating'
  - Marital discord, separation, divorce
  - Neglect / Abuse of children
  - Psychopathology in other family members:
    * Depressive disorder - wife
    * Conduct disorder
    * Emotional disorder – children
  - Effects on family budget
- **Industry - work related impact**
  - Reduced / Loss of productivity
  - Absenteeism
  - Inefficiency
  - Reduced uptake of training
  - Lack of skill enhancement
- **Legal problems**

ISSUES IN ESTIMATION OF COSTS OF ALCOHOLISM

- Cost estimation – complex and controversial
- Costs – difficult to identify and quantify
- Incomplete / poor – epidemiology base
- Absence of routine information gathering system
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- Bias towards underestimation
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- Tentative, conservative, `Guestimate'
  (to be regarded as `indicative' rather than `firmly reliable')
- Alcohol produces **costly** problems of large and diverse extent
- Policy makers – ill informed about the costs and benefits of manipulating the demand for alcohol

ESTIMATION OF COSTS OF ALCOHOLISM

- Direct health care costs
  - Hospital treatment for alcohol related diseases / accidents
  - Treatment and rehabilitation costs within health / social welfare sectors
  - Sickness insurance
  - Disability pension

- Other Direct Costs
  - Insurance coverage for damages due to accident / crime
  - Criminal justice interventions – police / courts / prisons
  - Enforcement of alcohol related laws, alcohol control
  - Alcohol education, Research

- Indirect Costs Due To Loss Of Productivity
  - Due to premature death
  - Due to disability
  - Due to sickness absenteeism
  - Inefficiency, reduced uptake of training, lack of skill enhancement

- Value of lost life

In Finland (1990), costs of alcoholism amounted to about 3.5% of the G.N.P.

ALCOHOL RELATED PROBLEMS - RESPONSES

- Growing number of treatment centres
  - Special / additional facilities in existing psychiatric hospitals / units
  - Centres run by NGOs in India
    - * Less than 10 in 1986
    - * More than 250 in 1993
- Innovative treatment strategies
  - 'Camp Approach' (Ranganathan, 1996).
- Involvement of primary care sector
  - Training programmes, Manuals (A.I.I.M.S.)
- Educational and training materials
  - For patients, family members, health workers, counsellors (TTR Foundation)
- Community action against alcohol
  - Andhra Pradesh, Haryana, Maharashtra
- Greater involvement of NGO Sector
- Alcoholics anonymous groups
  - in smaller cities and towns
  - In local languages
- Employee assistance programmes (E.A.P.)

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MARITAL INTERVENTION

Vijay Nagaswami

- What is marriage?

- a committed, conscious, emotional, physical and sexual partnership entered into by two consenting adults

- with the objective of achieving a state of harmony between the yin and the yang

- and promoting a sense of emotional and spiritual well being in both partners

- `through the mutual resolution of unresolved intra-psychic conflicts

- and the harmonisation of the balance between the internal and external environments of both partners.

This definition includes all committed, monogamous relationships between consenting adults of either gender

The Purpose of Marriage

- Enhancement of self image

- Enhancement of identity

- Engendering physical, economic and social security

- Gratification of sexual, belonging, parenting and intimacy needs

- Resolution of intra-psychic conflicts carried over from earlier relationships

- Companionship and spiritual fulfilment, BUT MOST OF ALL

- BLENDING THE YIN AND THE YANG

The Location of Marriage

INDIVIDUAL

MARRIAGE | FAMILY & FRIENDS | WORK | COMMUNITY

INDIVIDUAL MARRIAGE

FAMILY & FRIENDS | WORK | COMMUNITY

The Anatomy of Marriage

- LOVE
- TRUST
- RESPECT
- INTIMACY

Marital Dynamics

- Search for unconditional love - impacts on LOVE
- Need for individuation -impacts on TRUST
- Playing control games - impacts on RESPECT
- Harmonising relationship patterns - impacts on INTIMACY

Manifestations of Pathology

- Each holding the other responsible for their respective unresolved conflicts
- Each viewing their respective extended family as a domain inaccessible to the other
- Inadequate definition of roles - hence competitive relationship
- Each seeking to derive their identity from their respective occupation
- Incomplete resolution of conflicts
- Avoidance of confrontation
- Incongruent expectations of or dependence on community
- Overemphasis on child-rearing with the children becoming the principal means of communication between the partners
- Disagreement on child-rearing process
- Inadequate attention paid to sexuality
- Seeking intimacy outside of the marital relationship
- Breakdown of mutual nurturing
- Conflicts regarding source of spiritual awakening

So, how can we help ?

Object of Intervention

To negotiate a compromise settlement between two warring factions?
NO

To assist a couple in relieving stress?
NO

To save the marriage from divorce?
NO

To empower the couple to make considered choices ?
YES

Couple Empowerment

- Facilitating the understanding of dynamics in the relationship
- Providing a framework to view the marriage with
- Learning to use the marriage to enhance individual identity

Goals of Intervention

- Redefine location of the marriage
- Each to take responsibility for respective self
- Enhancing love, trust, respect and intimacy
- Redefining relationship template

Types of Intervention

- Pre-marital
- Marital - proactive
- Marital - reactive (crisis)
- Pre-divorce

Intervention Setting

- Individual therapist
- Conjoint - two therapists
- Consensual - two therapists
- Group - one or two therapists

Intervention Techniques

- Negotiation
- Goal setting
- Interpretation
- Homework assignments

Stages of Intervention

- Stage I Negotiating the Contract
- Stage II Identifying patterns
- Stage III Formulating template
- Stage IV Review

Stage I : The Contract

- Provide overview of intervention
- Clarify expectations
- Provide overall formulation
- Set definable goals

Stage II : Patterns

- Need for unconditional love - unstated expectations
- Individuation needs - fight analysis
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Stage III : The template

- Redefining expectations
- Redefining boundaries
- Re-formatting fights
- Refining patterns

Stage IV : Review

- Review insights
- Review investment
- Set medium-term goals
- Set up periodic reviews

Schedule of intervention

- The Contract 1 or 2 sessions
- Patterns 4 to 6 sessions
- Template 2 to 4 sessions
- Review 1 session

Client-related issues

- Taking responsibility for outcome
- Client selection
- Recalcitrant spouse
- Dropping out

Therapist-related issues

- The need t0 mediate
- identifying with one partner
- Serving as conduit
- Therapist's own relationship

Who is the client?

THE MARRIAGE

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MH-2c.33

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M. Sundarraj
MH - 2c. 34.

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CAUSES OF ALCOHOLISM

DR. MOHAN ISSAC

- Multiple, interacting factors
- Different factors are important at different stages

'Bio-psycho-social model'

- Biological factors / theories
  - Genetic factors
    - * 3-4 fold increase in relatives of alcoholics
    - * No single major locus
    - * Twin / adoption studies
    - * Follow-up of children of alcoholic men
  - What is transmitted?
  - Individual 'vulnerability'

- Psychological theories / factors
  - Psychoanalytic theories
  - Behavioural theories (Learning, conditioning)

Alcohol – Reduces tension, effects of psychological pain, feelings of nervousness
- Enhances feelings of power

'Alcoholic Personality'
- cause or consequence?

- Psycho-social and cultural factors
  - Early childhood experiences and learning
  - Broken home
  - Faulty role models
  - Alcoholic father / parents
  - Family interactions
  - Social pressures
  - Demographic variables
  - Availability of alcohol
  - Affordability, cost factors
  - Accessibility
  - Laws related to alcohol use
  - Social acceptability of use
  - Peer pressure, peer behaviour
  - Cultural / social attitudes
    - Permissive
    - Abstinent
    - Ambivalent

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ANGER

Prepared by

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ANGER

Anger is a normal human emotion - to never feel it, is never to be fully human. Yet, this most common emotion can be the most destructive too.

Anger can work against the person. Anger fr·quently turns the very atmosphere into an alienating one, which in turn, prevents the individual from resolving his problem speedily. In the angry position, he finds himself unable to function effectively - which infuriates him further. When he fails to achieve what he wants, he turns critical of himself and of others. His anger spills over and he shows hostility towards other relationships far removed from the original cause.

Anger is a powerful emotion that can hurt a person physically. Getting angry, is like letting a high voltage current pass through the body. People who anger easily and stay angry, let themselves in for a list of health problems - headaches, skin problems, back-pain, ulcers, and even heart attacks. Anger is frequently the cause not only behind minor mishaps like tripping, knocking against furniture, etc., but also behind more serious problems like accidents, fist-fights and even murders.

Two radically different forms of expres ı of anger are delineated below. While some people display them to the last letter, most exhibit different shades between the two extremes. With the same individual, expression may depend on the situation or the person, one is relating to.

i) **'Hot Head'**

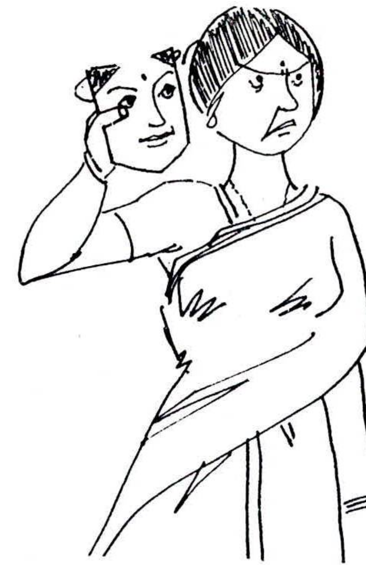
He is well known for his impulsive outbursts, and frequently goes blind with rage. He freely vents his feelings and often says things he does not really mean. His anger hurts people's feelings and consequently breaks relationships permanently.

Since the aggressive content is high and his complaints are not clearly voiced, he is met with disapproval, and actual issues go unnoticed. Resentment towards him grows and people move away or simply write him off and never take him seriously.

He expends a lot of energy in his fits of anger, but achieves practically nothing.

ii) **'All Sweetie'**

She keeps her anger, even when realistic, to herself, to avoid open conflicts. She burns with anger inside; but struggles to maintain a calm exterior as though nothing hurts her. In doing so, she ends up as a store-house of anger and rage.



She does not object to the unfair treatment meted out to her. So others see no reason why they should change. She either moves away and lives in loneliness to avoid further hurt, or continues to hide her feelings with a gnawing pain.

Anger, in both these cases, is displayed inappropriately - vented ineffectively or turned against oneself. In either case, nothing is gained through anger.

We cannot ignore anger or totally eliminate it from our lives. Anger is neither "good" nor "bad" - it just is. Anger always exists for a reason and therefore deserves attention.

PRACTICAL GUIDELINES

You can minimise, if not totally eliminate self-defeating anger and yet deal effectively with people and situations. Here are a few suggestions that can help. **Pickup** at least **one or two suggestions** which would be relevant, practical and therefore **beneficial to** you.

1. **Express your problems and expectations explicitly**

Anger sometimes stems from unexpressed problems, desires and expectations. The mother who is nursing a bad head ache may simply blow up in anger if the child makes a request for a special dish. As she has not told the child about her physical problem, he cannot be expected to understand her pain and display concern.

Her angry outburst only alienates her further and she will not get the treatment she deserves.

When you are in a crisis and need help, ask for it. Most people get to know clearly that you need help only if you tell them so. The attitude of 'they ought to know' is not very practical.

2. **Speak out your problem by stating facts**

By expressing feelings and avoiding accusations, by being descriptive and not judgemental, one can prevent anger 'build-up'. Open discussion about the conflict clears the air and helps speedy resolution.

> Raju was invariably furious with his wife when he left for work. When shouting and angry lectures did not work, he decided to tell her specifically what he expected of her. "When lunch is packed late, I get tense because I might be late for work. That's why I shout at you. I become anxious and drive recklessly. I feel bad all day because I know I have hurt you. I would be happy to go for a simpler meal which can be prepared well in time." Raju found that this disclosure worked better than the usual outburst.

3. **Ask for clarifications**

Statements and questions designed to get the other person to speak his mind are very helpful.

Being just as curt and grouchy as your colleague has been, for the past one week, does not help in solving problems.

"I get the impression that you are unhappy with me. Are you?" - may invite him to speak his mind. Well, that may get you somewhere.

4. **Develop an assertive* approach**

Anger frequently stems from our non-assertive behaviour. We give in more than what is necessary, invite others to take advantage of us and subsequently boil with anger! If a colleague takes leave too often, loading you with an unfair share of work, you can firmly refuse to 'pitch in.' Carrying that anger inside and being 'testy and nasty' all day long, will permanently disrupt the relationship with the colleague and hurt you also.

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* Effective communication and assertiveness are powerful tools to avoid / handle anger. Brevity has been forced here, as elaborate discussion on these is beyond the scope of this booklet.

5. **Channelise 'anger energy'**

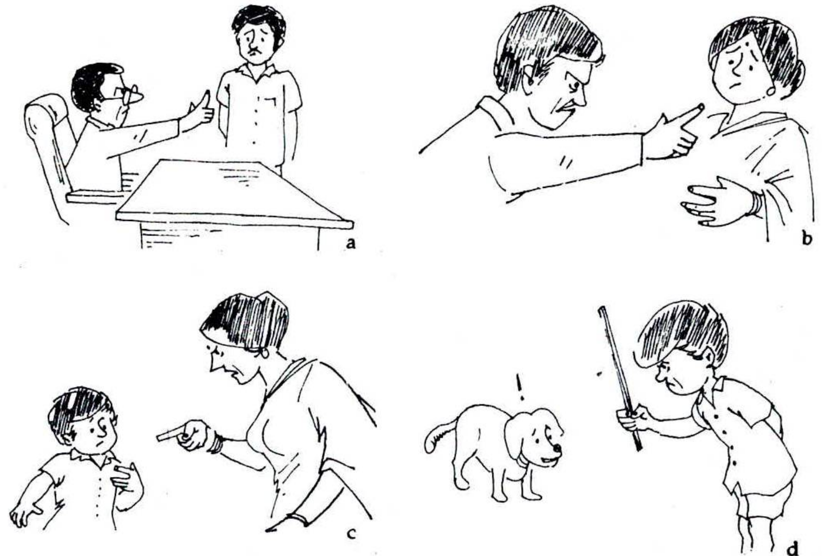
Anger produces a lot of energy. Some physical activity may help you to let off steam without hurting yourself or others. For instance, cleaning or tidying up the house helps get anger out of the system, for a housewife. Similarly you can think of some constructive activity to channelise anger.

> Prakash, sales executive, resorts to another method when he feels like 'shaking them till their teeth rattle'. "I write a stern letter stating each and every thing of what I feel. Feeling better after having let it out of my mind, I leave the letter aside for a day. By the next day, I usually cool off enough to think rationally. Sometimes, I feel it is not worth writing about and therefore destroy the letter. Or else, I tone it down, use more courteous language and send it across. This really works! I do not ignore anger. At the same time I **act** instead of reacting."

6. **Recognise 'misplaced anger'**

In 80 to 90 percent of the occasions, anger becomes **misplaced.** When anger in a situation or relationship is not handled properly, it is spewed on to the other areas, leaving behind a trail of damages. The worker's disappointment in not being considered for an important assignment, may be carried over as irritability towards his wife. His wife, in turn, shows her anger stemming from this uncared-for feeling, on her children.

Your misplaced anger is vented frequently on people who are on your "can be angry with" list - your family members and not colleagues, your subordinates but not the boss. You may punish yourself by failing to handle basic issue honestly, and thereby let it weaken your healthy relationships too. Misplaced anger hurts more and more meaningful relationships just as a single stone can set off a number of ripples in a pool.



Stress at workplace is often the cause of anger in the home-front. Discussing work pressures with family members helps. Sharing makes them more sensitive to your problems and you get to enjoy their support too!

7. **Check the 'trigger'**

When your anger is scrutinised, you may identify a few specific situations or individuals with whom you anger easily. Identifying them can be a powerful tool to deal with your anger. For this purpose, maintaining an 'anger diary' for a fortnight or a month, may help. Being sensitive to anger in its disguises (silence, sulking, banging doors or avoiding people) is imperative. In the 'anger diary' note down all events or situations which 'upset' you.

Analysing will bring to light the angry situations and their associated triggers.

8. **Realise the link with hunger**

Hunger and anger have much more in common than the last four letters. When the body is devoid of its energy, a person is not himself fully. Fatigue can make a person anger fast.

Trivial things seem major disappointments and slight disagreements can lead to heated arguments. Discussions, especially those in which disagreements are anticipated, are best scheduled after a meal.

"Feed him if you want him to stay calm" seems a good idea.

Priya takes a lot of interest in her husband's work; but all her questions only elicit curt replies. The reason is only too simple - wrong timing. After the day's work, he needs time to switch roles, relax and talk. With some food and time, he may unwind and be more pleasant.

9. **Avoid letting anger 'build up'**

Anger, even when reasonable, if left far too long, festers like an unattended wound, and turns into resentment, bitterness and hatred. Past resentments - injustice done by one's parents, siblings or acquaintances - are normally carried over as an unbearable load.

Forgiving and 'letting go' has to be done by exercising our will. Seems difficult, but is there a better option? To let bitterness and resentments remain, is to permit them eat you from within - a slow suicide.

10. **Developing a flow chart for handling anger**

Devi, a teacher, finds the following steps helpful in dealing with anger.

Step 1

Am I just upset or am I 'somewhat angry'?

Step 2

If I am angry, is it because of something which happened now, or, am I carrying it over from elsewhere?

Step 3

If I am carrying it over from elsewhere, it is misplaced anger. In that case, let me tell the person "Give me sometime, I will

get back to you." Theret I acquire some time to deal with anger. I avoid unloading it on the next unsuspecting victim.

Step 4

If it is not misplaced anger, and the cause of anger is clearly known, let me analyse and think about it. If necessary, let me talk it over with somebody I trust.

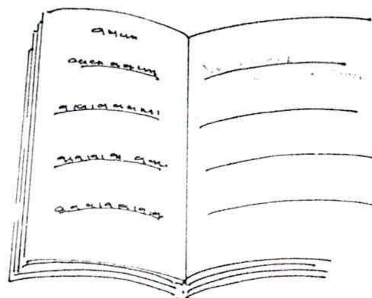
Gopinath, an executive, used the following model, involving simple analysis, and application. He achieved it in three stages.

Stage 1

Analysed my anger patterns :

- Shouting, screaming at subordinates
- Upsetting wife and children for no specific reason

Stage 2



Identified specific situations/periods during which I felt angry

- Monday mornings, soon after reaching office
- Day of resuming work following a tour
- Month end (Performance reviews?)
- For about 30 to 45 minutes preceding lunch break
- For about 30 to 45 minutes after reaching home

Stage 3

Took appropriate steps to avoid or deal with those situations:

- Ate regular meals - especially breakfast (reducing 'prelunch acidity')
- Went for work an hour earlier during peak periods to organise myself and set targets for others
- Scheduled meetings involving disagreements after lunch
- Requested family members not to raise issues for decision as soon as I reached home.
- Reviewed my anger at work and at home every day, and continued doing it for a month.

These few steps really worked!

Using any one of these tools in isolation, or in combination, you can arrive at a model suited to your needs. With this tool in hand, you can check your daily progress about how well you adhere to goals you had set for yourself.

You may recover from unhealthy anger by sticking to the 'one day at a time' principle. Set goals for each day and hold on to them for just '24 hours.'

Anger is wholly yours to change. Assume personal responsibility for your unhealthy anger patterns and resist the urge to blame others for your anger.

You may start with family relationships - which are usually the most influential and the most difficult, and then move on to other less complicated ones.

Remember

- Practical guidelines are available to you to minimise 'anger reactions'
- You should develop your own model based on these guidelines
- Even if one or two ideas can work, it could give you tremendous relief
- By minimising anger you become healthy and assertive.

Should anger be allowed to obsess your thinking and ruin your life?

Should you punish and destroy yourself for what others are doing?

Exercise your choice.

Handle anger sensibly and

Become a 'BETTER YOU'.

COMMUNICATION

A "BETTER YOU" SERIES-4

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New Delhi 110 001

COMMUNICATION

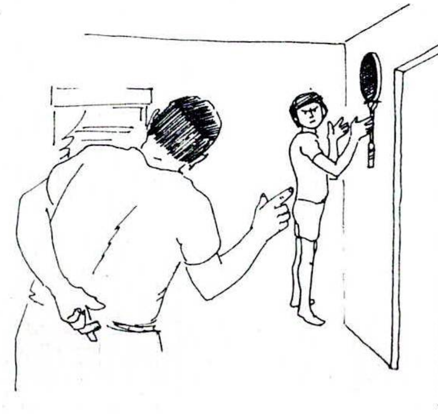
Your 17 Year Old Can Be Your Best Friend

"Why do little kids grow up as adolescents at all!" Ganesh thought wearily. He and his seventeen year old son could not spend a few minutes together without snapping at each other.

"She is a stranger to me now!" Rukmani exclaimed, confused at her teenage daughter's `inconsistent' behaviour.

"Where did I go wrong?" Thomas lamented. He had so much looked forward to a `camaraderie' with his son when he grew up and now this seemed impossible.

"Generation gap!" says the arm chair psychologist.



"They don't care for elders", complain many, shaking their heads despondently.

"It's no use" exclaim a few who find refuge in avoiding arguments with the adolescents.

"There is no way out!" the pessimists give up!

"Does it have to end this way?" distraught parents question.

No, not at all! Your adolescent child's difficult behaviour does not signal his loss of respect for you or all that you stand for.

It only points to the need for communicating better.

'Generation gap' is a myth. A term, we take refue in, use conveniently to der.y our contribution to the problem and convince ourselves that nothing can be done. Generation gap does not exist - communication gap does, and this gap can be bridged - if only you really care.

This booklet carries views, opinions and examples of parents who have trudged up this path. With effort, they tried different methods of communication and surprisingly enough, these worked! We invite you to try them and experience a closeness with your child.

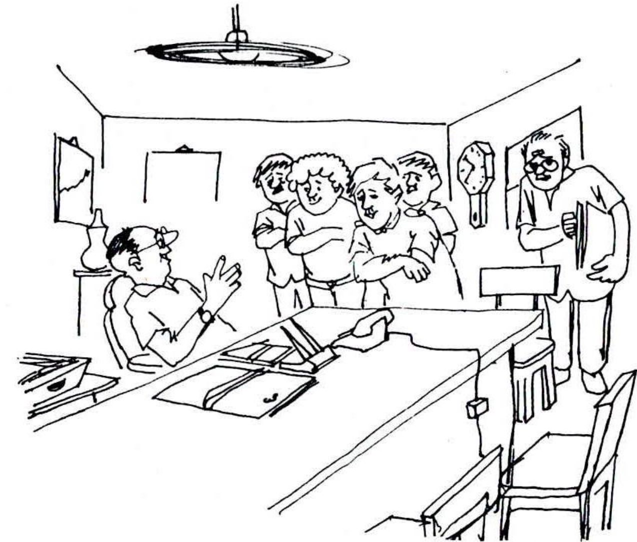
Before you proceed, let us clarify two doubts that may be foremost in your mind.

1. "My parents brought me up this way and I grew up right; why doesn't it work with my son?'

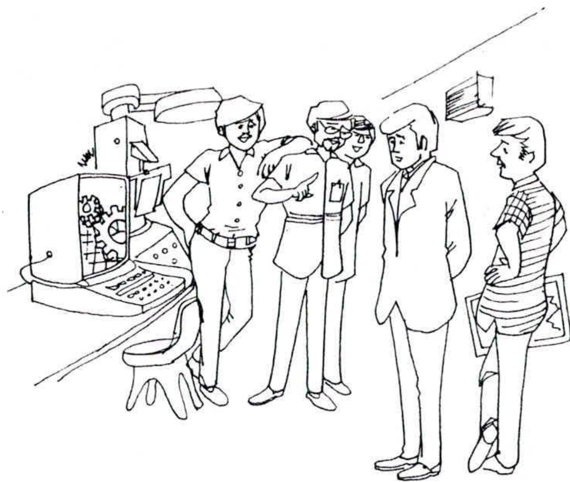
   World is no more the same. It has changed a lot. The whole scene is different now. Take a walk in your home town - see if anything is the same - the way people dress, eat or shop. There are a few 'decades' between you and your adolescent son and that is a lot of time, and consequently `a lot of change.'

   Ramnath says,

   "The way I run my firm is vastly different from the way my father ran it. During my father's days, the workers stood around reverentially.



Now there is union; we exchange views and involve the workmen in the decisions we make. Autocratic system is breaking down everywhere.

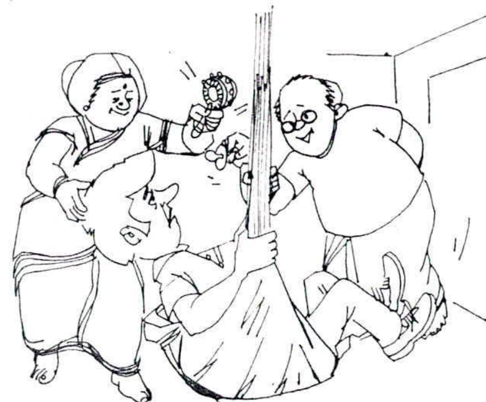


I am aware of the enormous changes that have taken place all over. I know my father's management will not work today. But at home, until recently I fought desperately to keep a rigid hierarchy. No wonder I failed with my son! The nasty scenes I had with him every day were proof enough for this".

2. "I have been bringing him up this way since he was a child. So why change now?"

He is different now. Isn't he? Every adolescent wants you to recognise that he is big and demands to be treated like an adult. When he isn't, others have a problem.

Looking back, Joseph says "I was incorrigible then. I expected my 17 year old son to `obey' my orders the same way as he did when he was a child. I expected him to take up more and more responsibilities and behave like an adult, but, persisted in treating him like a child!"



Smaller children may accept instructions more easily and act the way you want them to. As they grow up, they do question your authority and no longer hide their resentments when parental pressure is used. Punishments which did work well in the past, now backfire. Trying to cow them down with threats, may only taunt them to pay you back with the same coin.

Every adolescent is trying to find his 'bearings' in the adult world. He is often all at sea - confused about what he should do or how he should behave. He needs an anchor to hang on to in this period of turbulence. **He needs you.**

This is a period when crucial decisions are made - decisions that will mark his future. Only when a strong parent-child relationship exists, can you influence him to take the right decisions. He needs to stay emotionally close to you. And, you need to help him stay this way by communicating well.

Be alter to non-verbal cues

Your adolescent son or daughter may often wear a woe begone expression, seem withdrawn or start sulking when things are

not going their way. These may be invitations to initiate a conversation.

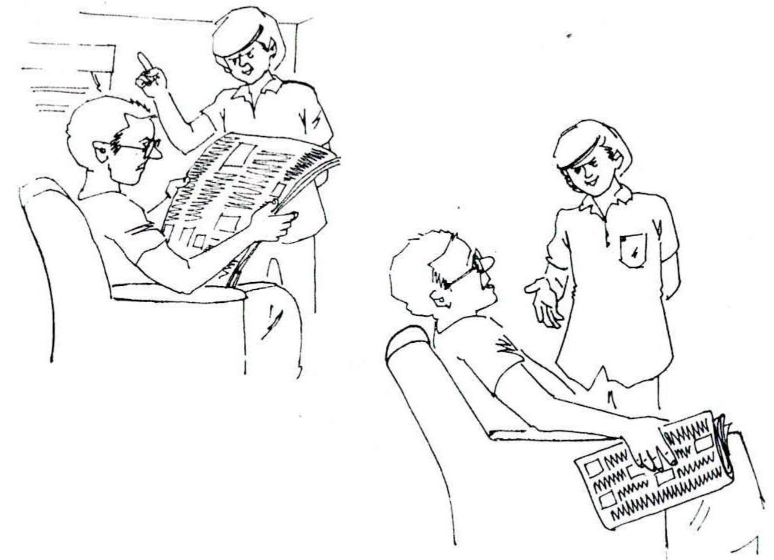
"You seem upset about something" - will be a statement enough to get him to talk about it. It shows your concern and willingness to help too.

Remember, the teenager today is made to study at the school level as much as what we parents studied at college level! Over and above that, consider the kind of competition they are pushed into in pursuing higher and higher grades or ranks. A teenager today has one hundred reasons to feel insecure, anxious, tense and 'highly worked up'.

Normally, we parents get worked up when our son indulges in long telephone conversations with his friends or when our 17 year old daughter spends hours together in front of a mirror. These are really minor issues and are best ignored, as arguments about them will only worsen the situation. **We often waste our energy in handling trivial matters like these, which in turn, weakens our relationship further.** When our focus is on minor matters, really serious issues are likely to go unnoticed.

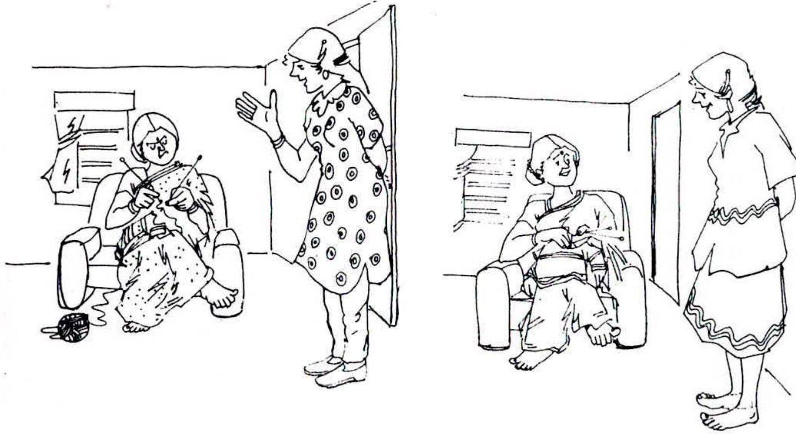
Listening - First Step to Emotional Closeness

Relationships grow with effective communication. Effective communication takes place only with 'effective listening.' Good communicators are essentially good listeners.



Listening is much more than just hearing. When you are trying to listen while reading a newspaper, to your son's report of the debate in which he participated, you are not doing a good job of listening. Being mentally set to hear, does not suffice. Making the other feel it, is important. If you were to approach

your superior with a suggestion or request and he 'heard' you while skimming through a few papers how would you like it? Looking at the person who is speaking, conveys your willingness to listen and your respect for what he has to say. Eye contact, appropriate facial expression and a leaning forward posture will encourage your child to talk.



Listening means undivided, focussed and total attention, to the exclusion of distraction. When you listen really well, you model the behaviour of your child to follow. If you want him to take what you say seriously, treat his talk the same way.

Interestingly, listening well is an **enjoyable** activity and not an exercise. **It tells you more about your child** and **draws him closer to you.**

Says one parent,

"Understanding the need to spend at least a little time with my son each day, I forced myself to it. It was with some misgivings, no doubt. To my surprise,

my son did make interesting conversation. He knew much more than what I credited him with - the recent political crisis, the business takeover by a tycoon and so on. And until then I thought, my 16 year old cared for nothing more than cricket and the latest piece of jazz."

Listening helps you to really get to know him - his hopes, aspirations, interests and friends, in addition to his hurts and pains.

Only when good listening is established during normal days, he will turn to you in moments of trouble. When he sees in you a 'confidant' and is sure of receiving a patient hearing, he will be willing to lower his defences and air his feelings and thoughts.

Reacting to feelings and not words

Listening means listening to what is said and also to what remains unsaid. Feelings are the vital part of messages which are often hidden. A good listener senses and understands the feelings behind the words. When the feeling content is ignored, we unconsciously place blocks and prevent the other from communicating. Figuratively speaking, we muzzle the other to stop him from speaking.

Ashish walks in, crest fallen, throw his books in a corner and makes an announcement.

"I am not going to the Maths Tutorial any more. I hate the teacher."

Typical responses which block communication will be:

"Don't throw the books that way" :- Criticism

"Without going to school, what are you planning to do - rear pigs? :- Ridicule

"Pick up those books and come and have your tea!" :- Order

"You have to go to school, if not, I will make you!" :- Threat

"You are a bright intelligent boy, you should not speak like that!" :- Praise

"Teachers are to be respected, you should not use terms like these!" :- Moralise

"You must have done some mischief and got into trouble!" - Blame

"School education is important for you. Without education you will be nobody..." :- Advice

An effective communicator would have probably proceeded along the following lines:

(Seen the facial expression and the act of throwing books as signs of strong negative emotions)

Mother : "You are upset about something which happened in the school!"

Child : "That teacher is stupid!"

Mother : "You seem to be angry with your teacher!"

Child : Yeah! She insulted me for nothing. I had just forgotten to take my book and she took off."

Mother : "She reacted badly, because you had not taken the book?"

Child : "And in front of all the students too!"

Mother : "It was embarrassing."

Child : "Some giggled. Arjun made faces. It was a bad scene. If only I had taken the book..."

Mother : "You are just wishing that you had remembered."

Child : "Yes! I guess I need to be more careful. I meant to take it, but in the morning rush to school, I just forgot."

Mother : "With so many things to do in the morning, you missed out this."

Child : "I think that hereafter I will get my things together at night before I go to sleep! I have always meant to do it, but, put it off. In future I am going to."

Here she has resisted the temptation to use blocks and pressurise the child into doing what she wanted him to do. By listening **without passing judgements** and reflecting the feeling to him, she helped Ashish. Negative feelings have been ventilated and the situation has been resolved.

Listening by **focussing on the feeling** content of the messages sent, helps the child resolve the problem situation. This may take a little time; so do not attempt it when you are hard pressed for time. It would be better to get back to your child when you have time at your disposal rather than try to rush

through in hurry. If the child seems unwilling to discuss it, do not push. She may get back to you when she does need a patient ear.

Communicating a need for change

Communicating a need for altering unwanted behaviour does not necessarily lead to hurt feelings. Change can be achieved in a smooth, non-threatening manner.

When the parent disapproves of the child's behaviour traditionally, solution messages are sent.

"Remove the books from the sofa immediately." :- Ordering, Commanding

"If you don't clean up, you will not be allowed to go the party." :- Warning, Threatening

"There's a place for everything and each should be in its place." :- Preaching, Moralising

"Why can't you put your books back as soon as you finish with them?" :- Shouting with indignation.

With these responses, the desired action might be achieved, but only with some negative feelings. At times, your child may decide to pit his prowess against you. In a battle of wits and power, your child is in a better position to win, for he has all the time and energy at his disposal.

Here's what a few parents say:

- "Getting him to remove his books from the sofa, takes atleast half an hour. I am often so tired that I do it myself."
- "When I did not give him permission to go to the party, he told me he was going to the playground and went to the party anyway."
- "My lectures generally fall on deaf ears. Often, he would be out before I finished."

Descriptive messages which emphasise on feelings and avoid being judgemental, work well.

"I take a lot of pains to keep the house neat. When books are left on the sofa, I feel frustrated."

Ravi told his son, "When the music is played loudly, I am unable to proceed with my reading."

He told this in a clam, even tone. Seeing that his music was interfering with his father's work, his son willingly toned down the volume. If he had been ordered to do it, still he might have done it, but probably not without resentment - "Do I not have the freedom to even listen to music in this house? The music was not too loud after all."

When her son arrived at 7 p.m. instead of at 4 p.m., Savithri told him "I was very anxious. I kept imagining the worst. I was so worried". This response elicited a honest "Sorry, I had a problem" from him. If she had responded in the usual manner saying "Where have you been? Do you think this is a hostel, where you can come and go when you please", he would have sulked and muttered a few unpleasant words.

In the above mentioned positive responses, the **focus** is **on the behaviour** that is causing the problem and **not on the person.** Since the person is not being criticised in an unconditional manner, he is not forced to defend himself. As the feelings are correctly described, the other person is not able to criticise in turn.

When any particular behaviour of your child is hurting you, frame statements with the following components:

1. State the problem behaviour
2. Describe your feelings
3. State the effect of the behaviour

With these statements, the child's willingness to change, becomes stronger, as negative evaluation is kept at the minimum, Compliance is higher.

Expressing feelings openly

Very often we mask our true feelings, twist them out of shape and express them in a negative manner.

> Vijaya left her lunch box at home. This has happened thrice this month and she just had a soft drink during lunch time. Typically, her mother, retorted in the evening saying, "How can you be so absent-minded? You don't do anything around the house after all. It is packed and given to you, and you cannot even remember to take it. If your memory is that bad, no wonder your test results are poor".

Vijaya felt resentful about the hurting remarks and walked away muttering "Big deal!"

On the other hand, if Vijaya's mother had expressed her positive feelings, her response would have been different. "You must have been hungry all afternoon. I had taken pains to pack your lunch and I was disappointed since you could not eat it."

Here, Vijaya gets to feel the positive feelings and would probably tell herself to make sure that this is not repeated.

Later on also, Vijaya may forget to take her lunch. But when she does so, she is going to feel sorry and atleast the negative feelings will not be there.

It is Easy to Sound Persuasive

We unconsciously mouth the same destructive responses that our parents used. We are so familiar with them that we say them with ease - without a thought of what it is doing to our relationship. When I was an adolescent, I vowed not to speak to my children the way my parents did. But here was I, a parent, now saying the same things in the same tone.

To take a sample - What happened if my children did not come to have dinner quickly? The old dialogues rolled off my tongue with ease. "Are you deaf? Why can't you come to dinner on time? I have so much of work to do later. No body in this house bothers about my work....."

After a lot of thought I changed my responses to sound positive. "Dinner is ready. The rice is hot. The pappads are crisp. Come quickly" I cried out in an enthusiastic voice. They did come - and quickly too. I felt more relaxed. I didn't hurt anybody for sure. I just made my words more pleasant and sounded more inviting'.

We are at our best with friends and worst where our children are concerned. Yet our children and their feelings mean a lot to us. Things will surely start working well if we treat our children with the same politeness and respect with which we treat our friends.

To sum up

- Children go through tremendous problems during adolescence. That is the time they need parental help. They may not ask for it. But the parents must understand.

- Relationships are built through good communication. And, all good communicators are essentially good listeners.

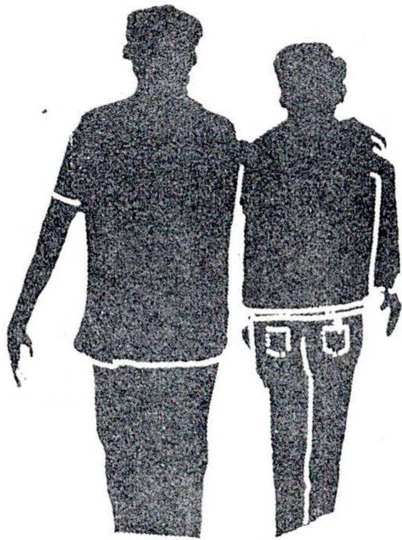
Good listening means listening not only to spoken words, but also to the teenager's feelings, emotions, impulses, interests and aspirations.

While suggesting a change in behaviour or habits, think and say how the change will benefit the kid. In any case, make sure that your focus is on the behaviour of the kid and not on him as a person. ("This behaviour hurts" instead of "You are hurting")

Think in term of "What it means to him." This ensures that the communication is persuasive.

Treat your teenage child like your friend. You will find that the 'your 17 year old' is, indeed, a good friend.

Become a better parent. **A BETTER YOU,** in fact.



EFFECTIVE WAYS TO CHANGE PEOPLE

WITHOUT OFFENDING THEM

A "BETTER YOU" SERIES - 6

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EFFECTIVE WAYS TO CHANGE PEOPLE

WITHOUT OFFENDING THEM

"I want him to change. I wish he could see the truth in what I say.... Will he take it in the right spirit?.. I definitely don't want to hurt him. What do I do? How do I communicate?" - This is the problem we quite often face.

More often, unknowingly we ride roughshod over the feelings of others, getting our own way, finding fault, issuing threats, criticising a child or an employee in front of others, without ever considering the hurt to the other man's pride! Whereas a few minute's thought, a considerate word or two, a genuine understanding of the other person's attitude would go a long way in alleviating the sting.

We want to point out ... and not be hated for it.

We wish to use words that influence and motivate the other to change.

How do we do this?

If we intend changing people without arousing resentment, we must begin with an attitude of respect for and acceptance of that person. His response totally depends on our attitude. We normally assume the right to point out others' mistakes; but never take the initiative to appreciate them when they deserve it.

If and only if we are appreciative when things go well, do we have the right to criticise. Appreciation makes a world of difference in the way our words are received and the motivation they provide to effect a change.

Compliment the person if you sincerely have something to appreciate in him. This will enable him to remain open to your criticism. Appreciation and Criticism should always be in the proportion of atleast 2:1.

Relationships that do not enjoy positive strokes will certainly not respond to negative feed back.

I WANT YOU TO CHANGE - HOW DO I CONVEY IT?

Words that attempt to bring about a change, most often sting and offend, not so much because shortcomings and mistakes are pointed out, but because our choice of words and their expression are faulty.

We want to ask the other person to change without sounding offensive or critical. How do we do this?

Here are a few valuable tips ....

Describe your feelings - The way it affects YOU

When judgements and negative evaluation of behaviour are made, the other person becomes defensive. Rationalisation and counter accusations follow. If others' feelings are commented on, they may deny or sound evasive. But when your own feelings are described, you leave no ground for argument or unpleasantness.

Sharadha's husband was away on a business tour. It was her birthday and she waited in vain for his telephone call. When he came back, Sharadha shouted, "You were so busy, that you could not even make a call.... Is it? All you care for is your business."

Her husband quickly reacted to her taunt and said, "Do you know how strenuous it is over there? You comfortably sit at home and think only of silly issues like these."

Instead, Sharadha could have said, "I was very disappointed. I waited all day for your telephone call." Through this response, she clearly states what she feels without finding fault with her husband. Now her husband is more likely to reply in a caring manner.

Words like 'bully', 'selfish', 'mean', 'useless', 'slow as a tortoise', 'dirty as a pig' etc. should definitely be avoided.

When labelling words are used and judgements are passed, the other finds only negative implications. If a change is to be effected, the other person should be helped to see your side of the picture and understand how his behaviour has affected you.

Describe situations without lecturing - Be brief

Our attempts to bring about a change often fail because we take over completely and lecture on what they should do and how.

Orders and directions that our lectures contain, tend to belittle their ideas and feelings. Just describing what we see, works.

When Senthil, a supervisor, saw his shop floor in a disarray, he told the workman, "There are tools.... also an oil spill. Watch out! With your workman's shoes on, you will slip". These words got the job done.

Senthil just described the situation and effected a lasting change in the behaviour of his workman. He says, "I had to say this only once. Since I got them to see the reason, they do it on their own now. Today I have the cleanest shop-floor in the factory - no effort and no ill feelings."

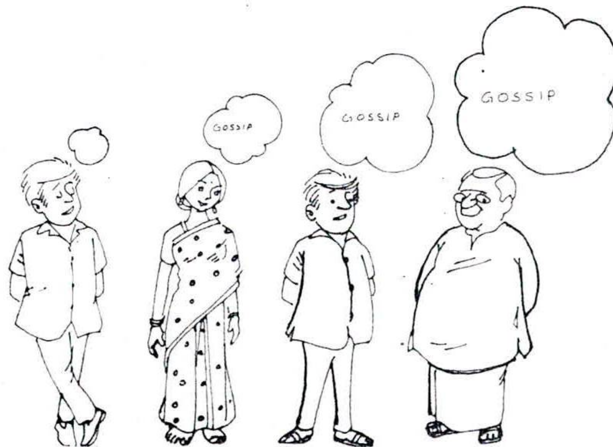
Instead, if Senthil had lectured, "Can't you see this mess? Didn't your factory's safety programmes teach you this? You want someone to point this out everyday?", a sullen worker would have done a half-hearted job and this too with Senthil monitoring him closely. Since the cleaning was done to keep Senthil's mouth shut, the shouting would have to be repeated every day.

Lectures on "Why can't you do that' and Don't you think you should', only stop the other person from thinking along those lines. Since you do the thinking and pick up solutions, the other person sees no reason why he should abide by it.

Express directly

Express your views directly to the person concerned.

When opinions are expressed through others, they take the form of gossip. They are given a negative flavour by each person who reports them. Your words can be twisted out of shape and turned unrecognisable.



When your neighbour plays music too loudly or dumps garbage on the road, the person you should speak to is **that** neighbour - not the others.

"When my colleague tells me that I should work faster, I can take that. But when somebody else reports it to me, I turn red. `What else did she say about me., How could she have.....', go my thoughts."

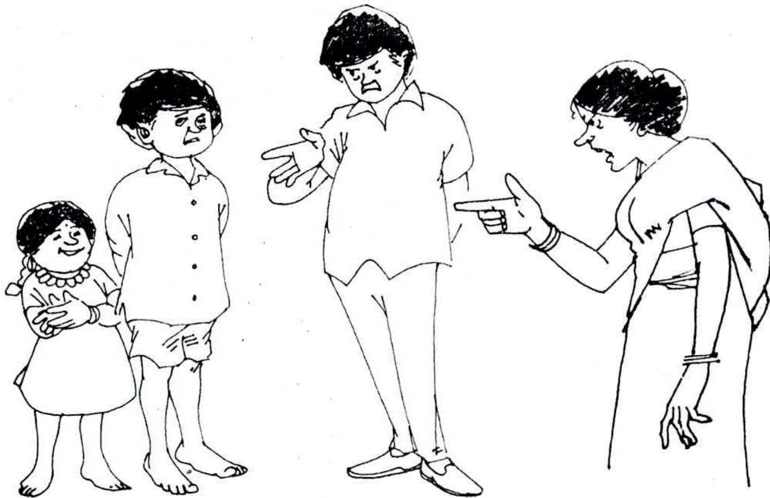
Complaining to others serves no purpose. It is similar to the act of the foolish man who lost his money in his field, but looked for it near the street light because it was brighter there.

Express your comments in private

Comments that hurt the most, are those that have been made in the presence of other people.

Embarrassed and angry with you for finding fault with him when others are around, the other person fails to understand what you are saying. For him, his feeling of being insulted becomes the prominent issue.

Akhil says, "I got into a scrap at school and my teacher sent a note. My mother was furious and she just took off. My brother said, 'He thinks he is too smart. He needs some shaking up.' My kid sister whispered, 'You refused to lend me your pen. See! God is punishing you. You deserve this.'



When I entered home, I was feeling very embarrassed and sorry about the note. After this scene, all remorse disappeared. I was just waiting to get even with my brother and sister."

If I am criticised when I am alone, it makes things easier - I have only one issue to handle - 'the problem'. With others around, a full set of forces come into play - What they might think, say and do, and how I should react to them.

When criticised in the presence of others, I feel I am challenged and my self-esteem gets weakened. When alone, defences are down. I am able to tackle the issue without having to play up to the audience.

Focus on only one issue at a time

When too many complaints are voiced together, we will not be taken seriously.

"Just look at your marks! You have failed this term also. You just do not bother to listen to us. You play till 7.00 p.m. every day with your friends. Your room is always in a mess, and I have to clean it up every time. Moreover, you don't hear what we say. Yesterday also I saw you shouting at Grandma. Getting up in the morning, eating on time - everything is a problem with you. I have to repeatedly shout at you from morning till night....." continued Lakshmi. Satish had stopped listening long back.

Focussing on just one issue at a time and expressing it clearly, is crucial for the message to be effective. When too many issues are presented at one go, nothing gets registered.

Moreover, when too many issues are pointed out, one feels worthless. "How can I handle all these drawbacks? With so many things thrown at me, I feel condemned and rejected."

Complaints are to be given in manageable doses. If given one at a time, the person can chew on it, think about it and assimilate it. An overdose can only turn him off.

Express verbally as to what needs to be done

If we are dissatisfied with what the other person has done, we have to explicitly state what we feel about it.

Sulking, banging doors, cold stares - none of these work. Non-verbal messages confuse the other, and he does not understand where he has gone wrong.

Murali came home late in the evening. When he entered, he found the whole environment different. His father did not speak to him at all. After half an hour, his father literally banged the door and went off. Murali was confused.

"What is wrong with Daddy? Why is he behaving like this? Has something gone wrong in his office"? - thought Murali.

Instead of sending non-verbal messages, Murali's father could have effectively told him, "Last evening I told you that you have to be back home by 7. I am upset because in spite of it, today you are late by one hour."

Do not sound apologetic

Feeling uncomfortable when criticising, we sometimes attempt to glide the pill. The crux of the issue will then be lost in the frills.

Ravi's boss said, "I am impressed with your qualification and the assignments you have successfully completed. As somebody much older to you in age, I feel I can tell you a few things. Coming to office on time, is something I consider very important. When I joined work, I used to come half-an-hour ahead of time and leave only after my boss did. Punctuality had always been my strong point. Imagine the model you will set to your subordinates if you come late. You are a young man with a career ahead of you.

So I want you to take care of small issues like these."

Ravi's boss sat back with a sigh of relief, for he thought he had conveyed to Ravi the importance of being punctual.

When Ravi's friend asked him what the discussion was all about, he said, "I don't know why he called me in. He was reminiscing about the past and telling me of things he did during his younger days."

Apologetic statements like, "I am saying it all for your sake", or "Don't get upset about what I am saying" are not required. They take the power off your words.

Avoid comparisons

Many believe that comparing unfavourably with another calls for a healthy competition. But it doesn't work. Instead, it leads to resentment and a total rejection of your views.

- "I have dined so many times at Rajesh's house. Unlike you, Rajesh's wife cooks marvellously well."

  "Curry is burnt and Sambar is too salty."

- "Shankar's handwriting is so neat. Look how untidy your work is."

  "Your handwriting is illegible."

- "You have not completed your target. Ganesh is less experienced than you. Still he has overshot his sales target. Why don't you learn from him and improve?"

  "I want your sales to increase."

In each of these, the first set of statements hurt. Comparisons offend feelings and deliver a blow to one's self-esteem. When a person is told time and again that he is not good enough, he will dismiss your standards and your words will lose their value.

Do not use words like 'Always' and 'Never'

Words like 'always' and 'never' dilute the power of statements and lead to a total disregard for your ideas.

Situation:

I accidentally broke a cup while washing it.

Criticism:

"You always keep breaking things. You will never change. You can never be trusted to do anything properly."

Reaction:

"When you are used to my being this way, and since I am not going to change, why are you wasting your breath?"

Situation:

"I lost my pen during the camp."

Criticism:

"You always keep losing things. You can never take care of your belongings."

Reaction:

"I lost a pen worth just Rs.2.00. This is the first pen I have lost. What about the purse that you lost last month?"

The statements here do not pin point particular behaviour, but rather condemn globally.

'Always', completely decries the past. 'Never' seems to say that one is bound to stay that way for ever. His reaction will then be, "True, I might be wrong just now - but there were dozens of times when I had been right. He does not even remember. He is too prejudiced. I will not listen to him."

Do not be sarcastic

Sarcastic comments fail to convey messages, but leave in their wake, hurt feelings.

- Dinesh silently finished his dinner of cold chapathis and left over curry. He said, "What an excellent dinner! Food is piping hot and absolutely tasty."

- Shantha entered office at 11.00 a.m. "You are very early. How did you manage that?", asked her boss.

John worked out the sum and showed it to his teacher. "With your kind of brains, you ought to be in a museum," remarked the teacher.

Statements like these are like acid that corrodes. The receiver only feels embarrassed, ashamed and furious. It does not help him understand where he has gone wrong. Even when he does, it does not motivate him to change.

So far, we have seen 10 cardinal rules to be followed in changing people without sounding offensive or critical. They are

1. **Describe your feelings - The way it affects YOU.**
2. **Describe situations without lecturing - Be brief.**
3. **Express directly.**
4. **Express your comments in private.**
5. **Focus on only one issue at a time.**
6. **Express verbally as to what needs to be done.**
7. **Do not sound apologetic.**
8. **Avoid comparisons.**
9. **Do not use words like 'Always' and 'Never'.**
10. **Do not be sarcastic.**

When we are right, let us try to win people gently and tactfully to our way of thinking; and when we are wrong - and that will be surprisingly often, if we are honest with ourselves - let us permit others to point out our shortcomings. It pays to listen......

It pays to listen patiently and with an open mind. Be sincere about it. Allow him to express his views fully. Suddenly

you may be tempted to interrupt. But don't. If you do so, he may stop abruptly and there may be quite a number of things he had wished to point out and you had missed.

Listening helps you to understand new truths - new angles to your personality which you may hitherto be unaware of. Convince yourself that his intention is not to find fault with you, but to help you to change for the better.

If others suggest a change, it does not mean that you are not valued. It only means that with the change, you will be valued more.

So far, we have explored methods to criticise others without offending, and also to listen to criticism and get benefited by it. Conscious practice of the valuable tips given, could lead to a turning point in your life. You already possess hidden assets within yourself that can make your personal and social interactions meaningful. All you need now is the determination to uncover, use them and become

A BETTER YOU.