Harmony of Life

T.T. Ranganathan Clinical Research Foundation
Chennai, India

THE NARASIMHANS

They Made It Possible

This vision of giving a new life to thousands of individuals affected by addiction and rebuilding their broken families, would not have become a reality but for the generosity and support of Smt Padma and Sri TT Narasimhan.

Sri TTN was steering the TTK group of companies founded by his illustrious father Sri TT Krishnamachari who later became one of India's most able Finance Ministers. When their eldest son, Ranganathan fell a victim to alcoholism in the prime of youth, the Narasimhans turned their grief into action. They encouraged his bereaved wife, Shanthi to train at the Hazelden Institute, a world-class institution in the USA and a pioneer in the treatment of addiction. It was at Hazelden that a determined Shanthi prepared herself for the purposeful task ahead – establishing a mission born of compassion and personal experience.

Narasimhans gave away their residence on the sea shore at Santhome to start a day care centre for treating the patients. From that time onwards, they have been providing support in many ways. With a financial contribution of 11 million rupees from the TTK group of companies and the commitment of TT Jagannathan, the spacious 60-bed TTK Hospital was built in 1987, with every modern amenity. TT Jagannathan's invaluable help continues, his support being enriched by the involvement of his brother, TT Raghunathan.

Two Decades of Care and Concern

God! Give me the harmony of life;
Caring friends, a good night's sleep...
A pleasant morning and a worthwhile day...!

Chamakapraśna

By the time an alcoholic or drug addict accepts his problem and agrees to undergo treatment, the lines of the Vedic prayer above have become meaningless to him. He has fallen out of tune with life, and has suffered several losses in every sphere of life - the loss of personal dignity, of family relationships, of friends and of finances. He knows no difference between day and night. He does not even know what he can expect from a good day.

The Genesis

In 1979, T T Ranganathan, in the prime of life, died of alcoholism. Treatment services were not available in India at that time. His young wife, Shanthi was shattered; but did not lose faith. She committed herself to making treatment possible for people suffering from addiction and helping their families recover from the painful trauma.

T T Ranganathan

A non-profit welfare organisation was born of Shanthi Ranganathan's personal experience and determination. The T T Ranganathan Clinical Research Foundation, as it was named, is a pioneering institution in the treatment of addiction to alcohol. It had its beginnings in 1980 in a house in Santhome, Madras and began to function with a small group of committed professionals as an outpatient facility. In 1985, the therapeutic services were extended to drug dependent persons as well.

Addiction management, however, is essentially a group programme. As patients began to arrive from different parts of India, Shanthi Ranganathan felt the need to change it to an in-patient programme, thus increasing the effectiveness of treatment. In 1987, the TTK Hospital was established, a 60 bed treatment and rehabilitation centre offering a month-long residential programme. Its ambience is one of unconditional support and hope for the patients, its charm, an abundance of empathy and compassion.

Shanthi Ranganathan

Activities
A Quick Look

Patient Care and Support

Community Rehabilitation

Research

Sharing Knowledge and Skills

Prevention Education

Treating Addiction
– A Demanding Mission

The Problem of addiction

Addiction, a chronic disease, is characterised by excessive and inappropriate use of alcohol or drugs. It leads to loss of control, which affects a person physically, psychologically, socially and spiritually. Treatment can help in arresting this problem and setting right the damage it has caused.

Who is an addict?

An addict is a person whose drinking or drug-taking leads to continuing problems in one or more areas of life - health, family relationships, employment, finances - and who, despite these problems, continues to drink or take drugs as he feels completely helpless. He becomes dependent on alcohol or drugs both physically and psychologically. Discontinuation leads to withdrawal symptoms ranging from stomach cramps to delirium tremens.

Treating an addict is virtually rebuilding the man. He has to be reconstructed, mind and body, brick by brick.

Goals of Treatment

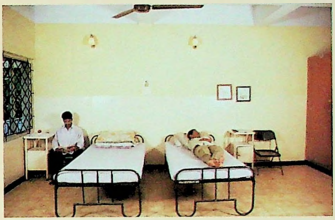
- Total abstinence from alcohol and other mood-altering drugs.
- Improvements in lifestyle – effecting positive changes in attitude and behaviour.

"About 55% of our patients treated so far have been able to lead sober lives", says **Mrs. Ranganathan, the Founder-Director of the Institution and the kinetic energy behind the mission**. "The rest do have problems in recovery. A good number stays on the borderline, alternating between relapse and recovery. We do not wish to claim that a patient has recovered, unless he is able to maintain a certain quality of life apart from leading a drug-free life."

Comprehensive Care

The hospital is surrounded by trees and is clean and airy within, an atmosphere conducive to recovery.

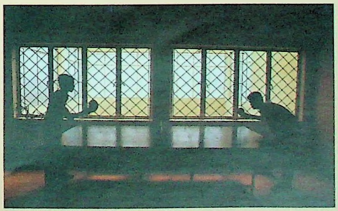
The hospital has 43,000 sq.ft. of floor space, and houses six general wards which offer a group environment for recovery. There are seven special rooms which can be occupied by patients and their families. There is also a family ward exclusively for the families of those admitted.



A 24-hour 'on-call' service is provided at the detoxification unit. There is also an emergency ward which accommodates patients who develop delirium tremens and those who turn violent.

An in-house pharmacy provides medicines required by patients.

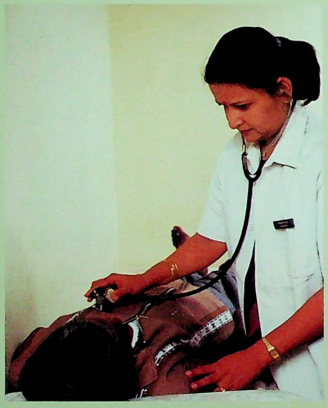
Apart from separate therapy centres for patients and families and a number of counselling units, the hospital also has a prayer hall and a recreation room. Nutritious food is served at subsidised rates in the canteen.



Patient Care

Enhancing motivation

The treatment process begins with an initial assessment of the patient by an intake counsellor. The problem of addiction is confirmed and the level of motivation of the patient and the support available to him are gauged. Patients usually deny their problem when they come for treatment, so creating awareness of the problem is the first step. The patient is then admitted into the primary residential treatment programme.



Medical management

Medical management or detoxification is necessary to make the withdrawal process from alcohol or drugs safe and comfortable. It is carried out under the supervision of the Director, Medical Services. Acute and chronic physical problems associated with abuse are also treated.

Psychological support

Once the patient stabilises physically, he moves to the psychological therapy wing where he participates in a highly structured programme. The programme includes community meetings, individual counselling, re-educative lectures, group therapy, art therapy and exposure to self-help programmes.

Internalising values

The day begins with a community meeting in which the counsellor narrates a value-based story. Patients relate this story to their personal experiences. This helps them to think meaningfully and make plans for the future.

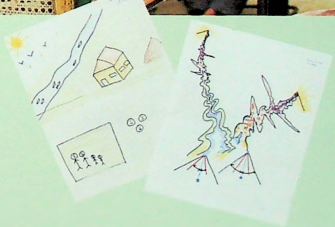
Sharing personal problems

Each patient and the family member who accompanies him are assigned a counsellor. The opportunity to talk to a supportive professional about their most intimate problems and experiences helps patients to accept reality, take on the responsibility for their own lives and develop renewed hope and confidence.

Experiencing a feeling of relief

During group therapy, patients talk about their painful past and express fears and hopes about the future. They are comfortable sharing their experiences with the others in the group who have also faced similar problems. The frank and constructive feedback from other group members breaks down denial and helps patients to recognise and acknowledge critical issues.

Art therapy gives patients an opportunity to express themselves through drawings. Even those who are not articulate find a way to express themselves effectively.



Practical management techniques

Re-educative lectures provide information about addiction - the disease concept, medical complications and denial. Methods of making positive changes are offered. These include ways to strengthen self-esteem, understand values and manage anger. The focus is on recovery issues such as relapse, dry drunk syndrome and methods to stay sober. The lectures have a practical rather than a theoretical orientation and each is followed by an activity which helps patients to assimilate what they have learnt.

Help for the Family -
An Integral Part of Treatment

Addiction leaves its impact not only on the patient but on every member of his family. Living with an addicted individual can be a painful experience and the family is deeply hurt and feels desperate. Therefore, the family also needs help. Healing the hurts and improving the patient's relationship with the family are essential elements in treatment.

At the TTK Hospital, family participation is a mandatory condition for treatment. This is a group programme with emphasis on fellowship. Re-educative lectures, group therapy, counselling and self-help meetings constitute the recovery programme for the family.

Viewing addiction as a disease helps family members to accept the patient better. Family members are also given directions to deal with their problems and improve the quality of their lives, even if the patient's addiction continues.

Making use of social support

Identifying and strengthening essential support for the recovering person, will help the patient in sustaining recovery after the primary treatment. At the Hospital, the support persons (parents, siblings, employer, friends) are met individually by the counsellor and are appraised of the various aspects of addiction. They are also made aware of the need for regular follow-up, the warning signs and management of relapse.

Planning for Relapse Prevention

One of the major problems during recovery from addiction is relapse. The patient must be helped to lower the risk of relapse through structured exercises. Programmes for the planning of relapse prevention are held once a month at the hospital. These programmes help the patients to identify relapse symptoms and plan methods to prevent them. If the relapse has already occurred, the programme helps the patient to track and identify the symptoms he overlooked, and to equip himself better for the future.

Free ongoing support

Recovery from addiction is not just the cessation of drug use. It also demands adjustment to a new way of life. This new lifestyle can impose new stresses which require new skills to cope. During the initial stages of recovery, the patient thus needs more than mere grit - he also needs guidance and support.

To ensure this, the hospital offers all patients free follow-up services for a minimum of five years. Records of progress are periodically updated. Correspondence, telephone conversations and home visits are carried out to maintain contact.

Patients who have recovered celebrate their sobriety years as this date every year marks when and how a new life for them began.

From the Hospital to the Community

It was in Manjakkudi, a village in Tamil Nadu that Shanthi Ranganathan's attention was drawn to the distressing problem of dropouts from the local schools. The fathers of many of the students drank excessively. As a result, several of these students dropped out of school.

It was the intense concern voiced by a teacher of the school that made Mrs. Ranganathan think of extending the activities of the hospital to rural areas. The idea of conducting rural camps for treating alcoholics was thus conceived.

Reaching the unreached
– free treatment for the rural poor

The Objectives

Providing treatment at the doorsteps of the villagers, specifically tailoring the programme to suit the needs of the rural population.

Creating awareness about the problems associated with drinking among the rural public, and transforming the community into an enabling force to combat alcoholism.

Utilising the Infinite Power of the Community

Alcoholism is not the problem of a single individual. If it is not dealt with, it soon becomes a problem affecting the entire community, as it leads to violence, theft, insecurity and economic loss. For a rural community to live in a secure environment, the entire village has to be involved in tackling alcoholism. The empowered community has infinite powers to reform itself, a power which no treatment centre can ever match.

Camps in the last decade

TTK Hospital has in the last decade conducted over 50 camps in the villages of Tamil Nadu. At each of these camps, 25-30 patients have received treatment.

Visible life style changes

- After treatment and rehabilitation, many patients are able to get back to work and contribute to the welfare of the family.
- With every recovery, five or six other dependents - spouse, children and parents are relieved of tension and anxiety.
- Children who have dropped out of school start returning to their studies.
- Awareness is created and many people who have not experimented, decide not to touch alcohol. With the knowledge gained, several occasional drinkers have given up alcohol on their own. (This information has been shared by many village leaders).
- There is also a reduction in the demand for alcohol. (In a village near Manjakkudi, the 'Panchayath' or local governing body has banned the sale of alcohol).

Community Rehabilitation

Addiction to alcohol and drugs is a major problem in urban slums also. The TTK Hospital provides free treatment to urban slum dwellers. The hospital has adopted the neighbouring Ranganathapuram community in the Indira Nagar locality. Two camps have been conducted at which 45 patients have received treatment. The community leaders were also made aware of the need to make the community drug-free.

Extended Care at the After Care Centre

By 1986, drug addiction had become an issue of concern. The majority of drug users were young and lacked family support. They also did not have the vocational skills required for productive employment. So, the one-month primary treatment was not adequate for them. What they needed was extended care and support.

To cater to this need, after-care services commenced in 1989. A new building was constructed in 1997 to house the After Care Centre. It offers accommodation for 20 patients. The programme is residential and involves a three-month stay. The therapy aims at resolving blocks in recovery and helps in vocational rehabilitation.

Maya Varadharajan

Maya Varadharajan, the co-ordinator of the centre explains, "Treatment provided here includes medical help, psychological therapy and follow-up for five years. Yoga is taught to improve the patient's concentration and memory. It also helps in relaxation and toning up of muscles".

Support from industries

Industrial houses have been a great source of support in many ways. The vision of an After Care Centre became a reality, thanks to financial contributions from many sources including the TTK Group, the TVS Group and the Birla Group of companies.

Creating Alcohol-Free Workplaces

Alcoholism has been a major problem affecting the industries. Excessive drinking has been on the increase among employees. It presents a major threat to the safety, security, productivity and health of the work force. It leads to unpredictable absenteeism, accidents, deteriorating discipline and causes constant worry over product quality. When addressed as a `health and safety' issue, it can save social drinkers from becoming problem drinkers, and problem drinkers to accept help and become productive employees.

To enable industries to deal with this problem among their employees and improve their quality of work performance, TTK Hospital has developed a comprehensive package. As part of the package, the management and union members are encouraged to develop a policy towards creating an alcohol free environment in their workplace.

Apart from conducting effective prevention programmes, TTK Hospital provides methods to supervisors and managers to identify early phase problem drinkers through poor job performance. In addition, it helps in offering treatment, rehabilitation and follow-up services.

The Gains

- Focusses attention on how alcohol affects productivity and personal safety
- Creates an ambience wherein peer pressure can prevent people from drinking
- Motivates non-drinkers to feel proud of their abstinence
- Helps to motivate social drinkers to give up alcohol completely
- Enables problem drinkers to become productive employees

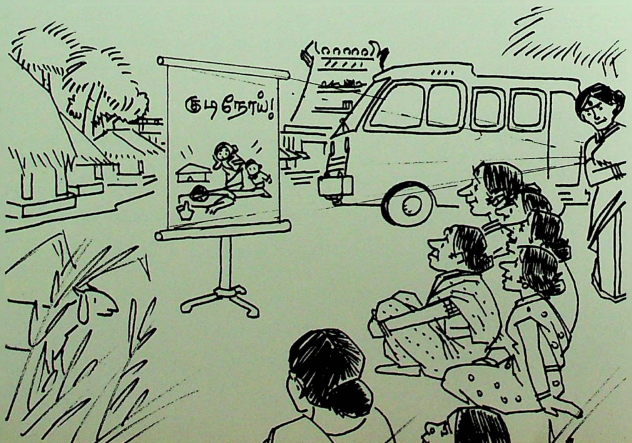
Education and Training
– *The Need of the Hour*

Alcohol is freely available today and restraints concerning its sale and use have become far too lax. Youngsters experiment with drugs like marijuana and brown sugar to complement what they think is a 'modern' lifestyle. The problem is widespread and has penetrated every stratum of society.

One of the vital reasons behind this is the lack of proper information. The TTK Hospital organises lectures in educational institutions, industries, welfare organisations, villages and urban slums to provide accurate information about alcohol and drugs so that people can make sensible, informed choices. Education programmes are conducted in English or Tamil. Prevention programmes are targetted at every section of society and different modes of communication are employed for each section.

The TTK Hospital has printed several posters drawing the public's attention to the impact of addiction, and exhibitions on the subject are held regularly.

Mode of Communication	Number of Events	Number of People Attended
Lectures	1061	74500
Exhibitions	257	51400
Video Shows	521	103000



Equipping Professionals

The TTK Hospital has been continuously providing specialised training in three areas of addiction management.

- early identification
- treatment methodologies and
- education and prevention strategies

Training programmes lasting from a single day to a week have been conducted regularly at the hospital for trainees from the grassroots level like the animators to medical, paramedical and industrial personnel apart from parents and teachers.

Students of psychology, social work, criminology, medicine and nursing usually confront addiction in their working lives, but are not equipped to handle it. To overcome this handicap and fill the gap in the curriculum, these students undergo compulsory training for a day at the TTK Hospital as part of their post-graduate course.

These training programmes have proved to be highly beneficial to society. In 1987, there were only a couple of treatment centres in India, but today there are more than four hundred. The majority of the staff in the treatment centres in Tamil Nadu, Kerala, Karnataka, Andhra Pradesh and Pondicherry have been trained at the TTK Hospital.

Addiction is a major problem in the North-East of India. The TTK Hospital has been identified by the Central Bureau of Narcotics and Ministry of Social Justice and Empowerment as an institution where their staff can undergo regular training.

This Hospital has also been recognised by several international agencies like the World Health Organisation, the Colombo Plan and the International Labour Organisation as a specialised training centre.

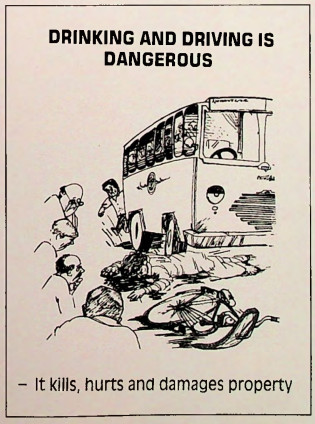
The Benefits

- People have direct access to 'hands on' experience
- The role of counsellors in addiction management is recognised and understood.
- Neighbouring countries with similar cultures like Sri Lanka, Bangladesh and Nepal also find the programme extremely relevant.

Addressing Current Needs

Campaign against Drinking and Driving

On a certain New Year's eve, ten teenagers died in three road accidents. The reason: drunken driving. The TTK Hospital enlisted the support of the insurance sector and began a campaign against 'Drinking and Driving' in Chennai for the first time in 1986. Such campaigns are now a regular part of the hospital's activities.



Prevention of HIV-AIDS

Another large scale social problem in Tamil Nadu is the spread of the HIV virus. At a treatment camp in Namakkal, a number of lorry drivers (who formed the majority of the patients) said they often had casual sexual relationships. This accounted for their forming a high risk group for HIV, but they were unaware of the danger they were exposed to. The TTK Hospital conducted several programmes for local health workers, teachers and the general public at Namakkal, Manjakkudi and Ranipet in Tamil Nadu. HIV awareness programmes have become a part of the centre's regular activities.

Addiction Research Centre

The Addiction Research Centre at the TTK Hospital has been recognised by the department of Science and Technology and enjoys 100% exemption from income tax. Several papers have been presented at international conferences and workshops.

The research findings are used by the hospital mainly for therapy modifications.

There is at the hospital, a documentation centre and a library with a large collection of research papers, periodicals, technical journals and books from all over the world.

Publications

The TTK Hospital shares its valuable experience in addiction management by publishing a number of professional manuals and books. These are culture specific and written in the Indian context. They address different target groups - professionals in the field, other service providers, patients, their families and the general public - and provide valuable practical guidelines.

Their latest publication addresses the school children and their teachers.

'*Give me facts... Let me decide*' shows the teenager how to build self-confidence and handle his choices sensibly.

'*Give them facts... Help them decide*' provides the teacher with powerful tools to create a new value based, well informed generation capable of making responsible choices.

Free Services at a glance

Free services are a part of the TTK Hospital from the day it was established and form the very basis of its philosophy. No one who comes for treatment is turned away because he cannot afford to pay. At the TTK Hospital, the same standard of patient care is offered to paying patients and those treated free of charge. The following are the services offered free.

Treatment and follow-up services to all patients in rural camps

Treatment to 20 percent of the TTK Hospital's patients

Follow-up services for five years after primary treatment at the hospital

Treatment and follow-up services for all patients at the After Care Centre

Education / training programmes

Professional Expertise

At the TTK Hospital, a team of 56 committed professionals provide medical and psychological support to the patients. This dedicated team has treated over 10,000 patients over the last twenty years.

L to R : *Jacqueline David* - Senior Counsellor, *Dr. Anita Rao* - Director - Medical services, *Shanthi Ranganathan* - Hon. Secretary, *Dr. RR Cherian* - Director - Research and treatment programme, *V. Thirumagal* - Director - Patient care and quality assurance.

The team includes a consultant psychiatrist, a physician, nurses, counsellors and administrative staff. The counsellors are psychologists, social workers or recovered addicts with qualitative sobriety who have undergone training in this field. The After Care Centre is managed by a coordinator, three counsellors, a resident warden, a physician, a yoga therapist and other supporting staff.

To remain updated in the professional practice, continuous in-house staff development programmes are conducted. Specialists of international repute from various institutions in allied fields, are invited to deliver lectures. A number of staff members have presented research papers and participated in international seminars in the USA, UK, Canada, Australia, Malaysia, Italy, Hong Kong and Thailand.

Volunteers in main stream activities

This institution has been singularly fortunate in its voluntary staff who contribute to mainstream activities.

Rukmani Jayaraman has over the last 12 years developed a number of publications for professionals, counsellors, recovering patients and their families. Her Master Guide on addiction treatment is used as a reference book by practicing professionals in the SAARC countries. Two of her books are being used by leading schools to impart Value Education.

Rukmani Jayaraman

Jaya Sadasivam

K. Ramdas Nayak retired from a senior corporate position in a bank to devote his time to organising and administering all the training programmes.

Jaya Sadasivam conducts group sessions for family members on a regular basis.

Vasantha Balasubramanian helps in administration.

Yoga Chandrasekaran looks after the information management function.

Collaboration with International Agencies

World Health Organisation

Consultants from WHO who visited one of the treatment camps found rural camps a viable approach for developing countries. Workshops were organised by WHO in Geneva, London and Colombo at which Shanthi Ranganathan was the resource person. The TTK Hospital has been chosen to train professionals from neighbouring countries like Myanmar and Sri Lanka under the sponsorship of WHO.

United Nations Drug Control Programme

UNDCP identified a few organisations in the country and equipped them to carry out their mission against drug use. In the year 1995, under the umbrella scheme, the Hospital received a van and some hospital equipment.

International Labour Organisation

The Hospital has been working on a few Community Rehabilitation projects in collaboration with the ILO. With their technical assistance, the hospital has undertaken projects to make two industries alcohol and drug free. One of the hospital's counsellors was sent to Delhi, Hong Kong and Bangkok to receive training on the ILO's community based rehabilitation reference model.

Colombo Plan

The TTK Hospital has been recognised as an ideal training ground for women counsellors, as most of the hospital's counsellors happen to be women. Also the family and community oriented treatment methodology at the Hospital is relevant to all the SAARC and ASEAN countries. The Hospital organised three training programmes for 46 women counsellors from these countries in 1997 and 1998.

European Commission

The EC provided grant to continue with the hospital's mission of providing after care services. With partial financial assistance from the EC, the 20-bed centre was built in 1998.

The EC also understood the hospital's need to train its staff. Under its sponsorship, the medical officer, the co-ordinator and a few counsellors underwent training at Kaleidoscope, London and at Centro Italiano Di Soliderata in Italy.

The Mission and the Vision

'What is it that has brought the TTK Hospital from its humble beginnings to what it is today?' 'The grace of God' says Shanthi Ranganathan. She continues, 'The team of committed professionals and the patients from different parts of the country who have continued to repose their faith in the hospital have been responsible for its growth'.

The quest does not stop with providing a beacon of light to those suffering in darkness. Shanthi looks ahead in her battle against addiction. 'Anyone in any part of India who wants to get out of the clutches of addiction, should have access to quality care. We will continue to share skills, knowledge and expertise, and equip the professionals to spread the concepts of care.'

'We will also continue with our mission of creating awareness so that more and more people make sensible choices. The number of new drug users should come down, and this positive change should be felt at the family, peer and the community levels.'

'Service is our motto and we will continue to provide it with utmost dedication, commitment and care'.

सर्वे जनाः सुखिनो भवन्तु ।

May everyone be blessed with Happiness and contentment

The T T Ranganathan
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AFTER-CARE CENTRE AND ITS DEVELOPMENT

PREPARED BY
MRS. MAYA VARADARAJAN
MRS. ARUNA
MS. KANAKAM

CONTENTS

WEEKLY TIME-TABLE

FORE-NOON

WEEK DAYS	06.00	06.30 - 06.45	06.45 - 07.00	07.00 - 07.30	07.30 - 09.30	10.00 - 10.30
Monday to Saturday	Rising time	Exercises or Yoga (Wednesday and Saturday)	Prayer (Thought for the Day)	Therapeu-tic Duties	Break-fast	Community meeting

AFTER-NOON

WEEK DAYS	11.00-12.30	01.00-02.00	02.00-03.30	03.30-05.00	05.00-06.00	07.00-08.00
Monday to Saturday	Lecture/ Assignment/ Therapeutic Games	Lunch	Group Therapy	Counse-lling	Recreat-ional activities	A.A. meeting and Counse-lling

I PHASE - I MONTH

I - WEEK

Morning	After-noon (Group Therapy)	Evening
Monday		
Disease Concept (Lecture)	Physical Damages	A.A. Meeting
Tuesday		
Assignments	Occupational / Financial Damages	
Wednesday		
Psychosocial Factors (Lecture)	Damages in the Family (Relationships)	
Thursday		
Assignments	'Feelings'	N.A. Meeting
Friday		
Surrender Vs Compliance (Lecture)	'Values'	

I PHASE - I MONTH

II - WEEK

Morning	After-noon	Evening
	(Group Therapy)	
Monday		
Human Needs (Lecture)	Spiritual Decline	A.A. Meeting
Tuesday		
Assignments	Social/Legal Damages	Stress Management (Lecture)
Wednesday		
Assignments	Emotional Damages	Assertiveness (Lecture)
Thursday		
Values (Lecture)	'Feelings'	N.A. Meeting
Friday		
Assignments	'Values'	

I PHASE - I MONTH

III - WEEK

Morning	After-noon (Group Therapy)	Evening
Monday		
Problems in Sobriety (Lecture)	Powerlessness	A.A. Meeting
Tuesday		
Assignments	Accidents due to Intoxication	
Wednesday		
Denial (Lecture)	Denial	
Thursday		
Assignments	'Feelings'	N.A. Meeting
Friday		
Relapse (Lecture)	'Values'	

I PHASE - I MONTH

IV - WEEK

Morning	After-noon	Evening
	(Group Therapy)	
Monday		
Self-esteem (Lecture)	Substitution of alcohol with drugs - vice versa	A.A. Meeting
Tuesday		
Self-esteem (Game)	Roles played by Family members	Anger (Lecture)
Wednesday		
Overcoming Grief	Cost of addiction in all areas of life	
Thursday		
Assignments	'Feelings'	N.A. Meeting
Friday		
Role Play	'Values'	

II PHASE - II MONTH

I - WEEK

Morning	After-noon	Evening
	(Group Therapy)	
Monday		
Personality Defects (Lecture)	Symptoms a) Preoccupation with drinking b) Black outs	A.A. Meeting
Tuesday		
Assignments	Increased Tolerance Loss of Control	Dry-drunk Syndrome (Lecture)
Wednesday		
Assignments	Grandiose Behaviour Insane / Aggressive Behaviour	
Thursday		
Chalk Game	'Feelings'	N.A. Meeting
Friday		
Smoking	'Values'	Group

II PHASE - II MONTH

II - WEEK

Morning	After-noon	Evening
	(Group Therapy)	
Monday		
Review of weekend	Relief Drinking or Life History	A.A. Meeting
Tuesday		
General Assignments (Self-esteem Evaluation Chart)	Values violated and Displaced by.	'Feelings' (Lecture)
Wednesday		
Time Management (Lecture)	Worst Drinking episode	Assignments
Thursday		
Assignments	'Feelings'	N.A. Meetings
Friday		
Ungame	'Values'	Group

II PHASE - II MONTH

III - WEEK

Morning	After-noon	Evening
	(Group Therapy)	
Monday		
Facing Challenges of life	Destructive Behaviour against oneself and others	A.A. Meeting
Tuesday		
Assignments	Methods used by family members to control addiction	Effects of addiction on sexuality (Lecture)
Wednesday		
'Values' Game	Grief over death of alcohol / drugs	
Thursday		
'Trust Walk' Game	'Feelings'	N.A. Meeting
Friday		
Assignments Self-esteem Evaluation Progress Chart	'Values'	Group

II PHASE - II MONTH

IV - WEEK

Morning	After-noon	Evening
	(Group Therapy)	
Monday		
Looking at self (Assignment)	Secret Guilt feelings	A.A. Meeting
Tuesday		
Quality of life (Lecture)	Loss of other interests	Warning signs (Group)
Wednesday		
Talents Time	Past adverse life style	
Thursday		
Memory Game	'Feelings'	N.A. Meeting
Friday		
Role Play	'Values'	

III PHASE - III MONTH

I - WEEK

Morning	After-noon (Group Therapy)	Evening
Monday		
Stamp Game	Life History	A.A. Meeting
Tuesday		
Inventory of Harmful Consequences	'Hurt Feelings'	
Wednesday		
Developmental Task (Lecture)	'Guilt Feelings'	Group
Thursday		
Warning Signs (Assignments)	'Feelings'	N.A. Meeting
Friday		
Snakes & Ladders Game	'Values'	

III PHASE - III MONTH

II - WEEK

Morning	After-noon	Evening
	(Group Therapy)	
Monday		
Defining personal goals and objectives - Assignment	Developmental tasks	A.A. Meeting
Tuesday		
24 hour programme - Debate	Developmental tasks	
Wednesday		
Clay modeling - Activity	Developmental tasks	
Thursday		
Re-appraisal of an 'upset situation' - Assignment	'Feelings'	N.A. Meeting
Friday		
Conceptualise 'self' - Self-esteem	'Values'	

III PHASE - III MONTH

III - WEEK

Morning	After-noon	Evening
	(Group Therapy)	
Monday		
Self disclosure - Activity	Pleasure vs Pain	A.A. Meeting
Tuesday		
A.A. Step - I - Assignment	Pleasure vs Pain	
Wednesday		
"I" - Puzzle	Anger / Resentments	A.A. Step - II - Assignment
Thursday		
Living Sober - Lecture	'Feelings'	N.A. Meeting
Friday		
Dumb Charade - Game	'Values'	

III PHASE - III MONTH

IV - WEEK

Morning	After-noon	Evening
	(Group Therapy)	
Monday		
Group art work	Review of stay	A.A. Meeting
Tuesday		
A.A. Step III	What are the advantages of my staying sober today	
Wednesday		
Inside/Outside Self drawing activity	Ideal qualities of a father/brother/son/ husband - Our Deviation	Group
Thursday		
A.A. Step IV	'Feelings'	N.A. Meeting
Friday		
Role Play	'Values'	

LECTURE TOPICS

The lecture topics covered by the Counsellors are listed below.

1. Disease concept
2. Psychological factors
3. Denial
4. Dry Drunk Syndrome
5. Values
6. Assertiveness
7. Relapse Prevention
8. Human needs
9. Overcoming Grief
10. Stress Management
11. Living Sober
12. Anger
13. Personality Defects
14. Problems in sobriety
15. Self-esteem
16. Surrender Vs. Compliance
17. Emotional cost of dependency.

SPECIAL LECTURES

1. Facing challenges of life
2. Quality of life
3. Myths and misconceptions of Esperal
4. Effect of addiction on sexuality
5. Feelings
6. Time Management
7. Developmental tasks
8. Smoking
9. Communication

GROUP THERAPY

Group therapy is a therapeutic mode used in the treatment of addiction. The therapy helps the patients to interact, share and discuss their problems with co-patients.

A group therapy is held at the centre every day at 2.00 p.m. Patients are in a closed group and each session lasts for about 45 minutes to one hour which is conducted by the Counsellor. Counsellor is never authoritative, rather she / he helps the member by monitoring, initiating and focusing on the topic. Each Counsellor conducts the group for a week. Group therapy is also held everyday in the evening between 7.00 and 8.00 p.m.

During the First phase of the programme the following topics are handled in the group. They essentially deal with damages during various stages of life due to addiction, reaction towards it and family's attitude.

Sharing

1. on physical damages.
2. on occupational damages.
3. on financial damages.
4. on social damages.
5. on emotional damages.
6. on legal problems.
7. on damages in the family.

8. effects of addiction on sexuality - damages due to addiction from minor discomfort to major complication.
9. effects of addiction on person's spirituality.
10. accidents (minor to major) due to addiction.
11. substitution of alcohol with drug and vice versa.
12. role played by family members towards our addiction - enabler, blamer, controller and protector, and its impact on us.
13. the cost of addiction.
14. loss of other interests due to addiction - socialising, recreation, hobbies, reading paper/magazines, intellectual conversations, political/discussions, etc.

During the Second Phase of treatment, programme topics mainly focus on symptoms and stages of addiction, to enable them to understand the disease concept and to break the denial of the individual.

1. Powerlessness

a) Preoccupation with drinking - this is one kind of powerlessness. Normal thinking abilities are marred by stinking thinking - pre planning, hiding and getting high with the plan.

b) Attempts to control chemical use - self attempts towards abstinence, making rules to abstain but breaking it, trying religious ways to abstain and go back to addiction. These methods also prove powerlessness towards addiction.

c) List the times an addict has lost control over his behaviour - black outs, getting into arguments / fights, a complete change of personality.

d) Sharing about - increase in tolerance level and loss of control.

2. Grandiose behaviour, insane / aggressive behaviour on intoxication.

6. Relief drinking situation - where one person feels relieved or addiction helps him to decrease the pain caused by the situation.

Conclusion - addiction never gave a permanent solution, rather taught inadequate coping mechanisms by escaping from the reality.

4. Values violated and displayed due to addiction - cheating, lying, stealing, begging, dishonesty, irregularity, irresponsibility and indiscipline.

Conclusion - how addiction made one behave in a negative manner - immoral and antisocial.

5. Worst drinking episode - accidents, harming others, indulging in violence, hurting others, stealing articles of expensive value etc.

6. Destructive behaviour towards self and others.

7. Secret guilty feelings - never shared with any one, embarrassing even now to think.

8. Methods used by family members to control addiction - eg. beating, house arrest, strict with money, emotional black mailing, pleading, begging, avoiding friend's visit, traditional / religious methods etc.

Conclusion - how ignorant family members are about the disease concept; how tolerant they were? The last attempt to control addiction will be this treatment and hence what should be done?

9. Denial

a) Denying the existence of any problem associated with use of alcohol / drug, the problems are quite obvious to others, but the addict denies the fact that his addiction has produced such adverse consequences.

b) Relate incidents of minimising - eg., "I accept that I drank and it led to some problems but the problems were not as much as others thought. In the process we convince ourselves that it is not very serious."

c) How the addict blames others for his addiction - blaming others for his own short comings. Denying the responsibility for many of his addiction related problems and shifting him responsibility to others. "I drink because my wife doesn't respect me or because people are unfair to me at work," etc.

d) Rationalising or giving excuses.

e) Justifying addiction.

10. Grief over death of alcohol / drug - whether we could accept the fact that addiction cannot or should not reappear in our life? Whether we feel a vacuum or gap due to this? Or can we feel that we have escaped from that addiction which will end our life. Hence we have to do something." Feelings towards this grief - shock, denial, unhappiness / sadness

and acceptance.

11. Past adverse life style - relate about a past adverse life style - spending excessively, grandiosity, guilty feelings constant tension in the family, lack of organised system in the family and self, not taking care of personal hygiene health etc.

12. Previous relapses - describe internal / external temptation.

16. Past craving experience - factors involved -internal thoughts towards drugs and external situations which triggered the cravings, about possible craving situation and methods to deal with them.

In the third or final phase of our programme, topics focus on making moral inventory of self, handling negative feelings (guilt, resentment, depression or anxiety) creating awareness of self towards reality, reviewing their stay and their future plan.

1. Identifying personality defects which maintained addiction - group confronts and helps the individual to identify his defects, and motivates him to change which will in turn strengthen his sobriety. Need for improvement of quality of life.

2. What does the addict think about "The ideal qualities of a son / father / brother. Have I had these qualities? Can I admit that I did not conduct my life in the right way and I have been irresponsible."

3. Narrate positive (personality) qualities of family members - How do I differ from my family members and become deviant in the family? How do they tolerate my traits in order to maintain the unity of the family.

4. The addict names the persons he dislikes / hates the most, and describes their personality traits - "can we identify same traits in our addiction days and during initial recovery? Do we have patience to wait till the family member / society accepts us, as they needed time to change their attitudes."

5. Developmental Tasks.

Robert Havinghust proposed the possibility that there are a series of developmental "tasks" appropriate to life stages. A developmental task is (one) which arises at or about a certain period of the life of the individual successful achievement of which leads to happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by the society and difficulty with later tasks.

Description of the group - In the beginning of the session, the patients are divided into 3 groups. The groups comprises patients between 18 and 26 years, 26 and 38 years and 38 years and above. The Counsellor then writes down on the board writes developmental tasks for the respective age groups.

Task for the age group 18 - 26 years are:

a) Completion of school education and entering college.

b) Completing college education.

c) Selecting and preparing for an occupation.

d) Developing intellectual skills and concepts necessary for civic competence.

e) Achieving socially responsible behaviour.

f) Building conscious values and morals.

g) Preparing for marriage and family life.

The tasks for the age group 26 -38 years are

a) Selecting a mate.

b) Learning to live with a marriage partner.

c) Starting a family.

d) Rearing children.

e) Managing a home.

f) Getting started in an occupation.

g) Guiding a congenial social group.

The tasks for the age group 38 years and above are

a) Achieving adult and civic responsibility.

b) Maintaining an economic standard of living.

c) Assisting children to responsible happy adults.

d) Relating oneself to ones spouse as a person.

e) Planning and saving for the future.

f) Establishing a satisfactory residential living arrangements.

Patient from the first group has to sit facing the entire group and the patients from each group ask him questions on the basis of the task mentioned on the board. The group members confront each about their achievement and failure which is due to their addiction.

Conclusion - Finding out disparity between chronological age and mental age. As mental age and its growth depends upon the achievements, accomplishments and approval from the society which stagnates / deteriorates due to addiction.

6. Anger / resentment / remorse - Before coming for treatment an addict was carrying a load of resentment, shame and guilt. "Has the programme helped me to relieve these feelings?"

   Conclusion - whether sharing of these helped addicts analyze the reasons, situations in a better way, and assess it in turn to improve communication, expressing, understanding others and relieving tension.

7. What are the advantages of staying sober today?

8. Pleasure Vs. Pain - In this group members were asked to give the period when they suffered due to withdrawals / turkey / hang over i.e. craving, physical tremors, stomach ache, joint pains, no money unable to get drug / drink due to physical discomfort or peddlars cheated them, extreme depression / anxiety / panic etc. They have to give in hours, days, weeks, months or years which will be very minimal as no one could tolerate these stress. Then they were asked to give the period of pleasure they had due to

addiction, i.e., high, kick, not feeling pain / ache, living in fantasy world which helps them to escape from worldly problems, enjoyed with friends, going for picnics / tours and spending lavishly. In this, patients will give the period of social drinking years which will be more than the pain / sufferings they had.

The Counsellor would ask the group, the period of pleasure they gave the family during their addiction days, i.e. presenting / gifting the family members, grandiose spending (buying flowers, sweets, clothes and delicious foods etc.) spending time with them happily, taking them to movies, tours and outings, laughing with them and creating happy atmosphere. In this, patients will be giving a very little account of days they gave them pleasure.

And finally they were asked to give the period of sufferings / pain caused to the family on addiction i.e., family faced depressive / anxious feelings, suicidal ideas / plans, biological dysfunctions (no sleep and no appetite) physically hurting and verbally abusing, constant tension, children were emotionally upset and showed academic backwardness, limited socialization due to stigma, debts and deprival of basic needs etc.

Conclusion - numerically the period, the group mentioned regarding their own pleasurable days will be more or less equivalent to the period of family members sufferings due

to addiction whereas the period of their sufferings will be equivalent to the period of family's pleasurable days during addiction days.

Generally the topics of deviance in the family, developmental tasks and pleasure Vs. pain will go on for a week.

9. Share about the incidents of past crisis situation and what was the coping mechanism used?
   - awareness of our inadequate / negative coping mechanisms
   - misconception / belief that alcohol / drug helped to come out from crisis or helped in minimising grief
   - realisation of how drinking / taking drug aggravated or worsened the situation which in turn produced guilt / shame. Example - death in the family, not in a position to help others in rituals nor could express our own feelings towards it.

10. Share about the feelings which are easiest / most difficult to express.

    Conclusion - negative feelings like hurt, depression / sadness / unhappiness, frustration, anger / resentment, disappointments and guilt were the difficult feelings to express. "Hence we seek the help of alcohol / drug which proves our inadequate personality and how we are going to express these in a normal way."

11. Review of our stay - the patient who is going to be discharged will share his experience at After-care Centre, what he has learnt and benefits, changes / improvements, and his future plans. Then the group will give their observations, suggestions towards his behaviour and also help him towards planning 24 hour day programme.

ACTIVITIES

Introduction

Since a growing need to supplement lectures and assignments was deeply felt by the staff of the centre, 'activities' were added to the programme. The advantages of group activity include peer support, peer pressure, the opportunity to practice social interaction and learning that others also face similar problems.

Many activities were added with the experience and growth of the After- care Centre. These activities were modified to suit the needs of the Centre. The activities are introduced to the group in the second and third month of members' stay at the Centre.

Energizers

Snakes and Ladders

Guess what is the word

Talent's Time

Gardening

Memory Games (a, b & c)

Clap together

Dumb charade

Self-Esteem

Warm Fuzzy

Cold Prickley

Feelings

I Feel

Ungame

Stamp Game

Inside / Outside / Self drawing

Debate

Values

24-Hr-a-day

Positive Growth

Values

Trust Walk

'T' Puzzle

Chalk Balance

Role Play

Self Disclosure

Group Art work

Clay Modelling

Review

Review of the week

Review of the weekend

Review of Patient's stay by other members.

'I FEEL'

Purpose

1. To make the patient aware of various feelings he experiences.
2. To make him express his feelings in a normal way.

3. To cut the association between drinking / taking drugs and expression of positive and negative feelings.

Materials

None

Instructions

This is an activity where we learn to express. During our addiction days whenever we were angry we had a 'peg' of brandy or a 'joint.' When we were happy at a wedding, we drank or smoked for expressing happiness. When the accounts did not tally at the office we drank/smoked to forget it. We had always used alcohol / drugs to express our feelings of sadness, happiness, tension, irritation or anxiety. We thought that emotional outlet was only through alcohol / drug. After we realised that alcohol / drug had become a problem to us, we are now taking treatment for it. Now while on the path to recovery, we should give up our old ways of expressing our feelings with alcohol / drug. With the help of this activity we will learn to express our feelings in a normal way.

Procedure

The members start the first round of any particular feeling by saying "I feel happy" and gives the reason for it or if he does not feel happy says "I do not feel happy" and gives reasons. In case he does not want to assign any reason, simply says "I feel happy", "I do not feel happy for no reason." Thus, the first

round of a particular emotion is finished when all patients participate. The second round of another emotion (for eg. sadness) can be started by any member of the group and it is continued till all the members express their feelings felt by them on that particular day.

Time Frame

30 to 45 minutes.

Note

The Counsellor also participates in the group. By sharing her / his feeling he / she can be a role model for patients to express genuinely and honestly.

VALUES

Purpose

1. To pick up behaviours that are adaptive and give up behaviours that are nonadaptive.
2. To set a creative mood and practice it sincerely.

Materials

A sheet of paper, pen.

Instructions

Our addiction has robbed us of good values like honesty, sincerity, etc. and good behaviour. When continuing with addiction, we never saved money (except for next drinks / drugs), we were selfish, we repeatedly told lies, we had even stolen for

drugs / alcohol. We did not care about personal hygiene. We were not dressed properly, or shaved or brushed or washed. Our eating and sleeping patterns were also very irregular. We came for the treatment and learnt that alcoholism / drug addiction was a disease and the way out of it was by total abstinence and improvement of life style. So it becomes necessary for us to change and commit ourselves for that change. The first step in changing ourselves, is to drop unnecessary habits and pick up good and healthy habits. So, now each of you are going to select a value (behaviour) which you would either learn or give up in this week. I would like you to work on the values through out the week (7 days) and we shall review as to how much you were able to accomplish by next week.

Procedure

The patient is asked to select a value. In case he is unable to identify, the group is invited to suggest some values to the member who accepts the necessary ones he likes and rejects the values with which he is not comfortable with. He is not compelled any further.

Time Frame

45 to 60 minutes.

Note

The value selected by each patient is noted down on a sheet of paper by the Counsellor. This sheet is then put up on the Notice

Board. At the next 'value activity' class, each patient is asked to share on, how he was able to practise the value. The group also reviews his behaviour. If he has not been successful, he continues with the same value. If he has been successful, he is encouraged to take on another value. During the value class, patients are also encouraged to write letters of amends.

SELF-ESTEEM - WARM FUSSY

Purpose

1. To boost up self-esteem of the group members.
2. To help members identify positive qualities in others.

Materials

Paper, Pen.

Instructions

Please write your name on the paper (right corner) and pass it to the next member on your right. Now read the name of the person (on the paper) and think what good qualities he has. Then write down 2 or 3 such qualities in the paper. Again pass the paper to the member on your right. This continues till you get your paper in your hand. Then stop.

Procedure

Patients sit in a circle and write down the positive qualities of the patient concerned on the sheet of paper. Patients are asked to go through the list whenever they feel low or depressed.

Time Frame

30 to 40 minutes.

COLD PRICKLEY

Purpose

1. To be aware of one's negative qualities or liabilities.
2. To help member learn to confront others' negative habits/behaviours in a healthy way.

Materials

Paper, pen.

Instructions

Please write your name on the top right corner of the paper. Pass the paper to the person on your right. As you read the name of the person (on the paper) think of his or her negative qualities i.e. qualities which are of negative influence for his adjustment with others and write one such quality on the paper. Then pass the paper to the person on your right. Continue till all the members' papers are passed. Then stop.

Procedure

The members sit in a circle and start writing the negative qualities after the Instructions are given.

Time Frame

30 to 35 minutes.

Note

The Counsellor also participates in the activity.

MEMORY GAME (a)

Purpose

1. To get each person involved in the group.
2. To make the patient aware of / learn about his memory process.

Materials

None

Instructions

Each one of you would start naming a city and the next person would mention the first one and call out his own choice. Thus it continues in a circle.

Procedure

Example:

1st Participant	:	Bombay
2nd Participant	:	Bombay, Delhi
3rd Participant	:	Bombay, Delhi, Madras.

The patient who makes a mistake is out.

Time Frame

30 to 40 minutes.

Note

The Counsellor also participates in this game mainly to get the group involved. The Counsellor can give a talk when the activity ends on the memory process, covering definition, the associative property of memory, the organisation on memory, the factor of attention, the factor of anxiety or memory etc., which would bring awareness to the members about the same.

MEMORY GAME (b)

The same as the above game (a) can be played with names of vegetables, flowers, etc. The instruction, procedure etc., are the same except in place of name of a city, the name of a flower/vegetable is to be used.

MEMORY GAME (c)

Purpose

To bring an exact awareness of memory process.

Materials

25 different objects of different categories ranging from small to medium size. (Blade, chalk, pencil, pen, rubber, screw, pin, vegetables (2), flower, leaf, seed, tablet, token, key, spoon, small ball, coin, stone, small length of wire, stapler, thread, needle, small cover, inland letter, papers, pen, etc.

Instruction

You now see different things kept on the table. Please have a close look at it for 5 minutes, after which these will be

removed. Take a paper and pen and write down the things you have just now seen.

Procedure

The Counsellor has to arrange on the table the different objects in a manner that they do not easily associate one object with the other. After the patients have a close look, the items are removed from the table and kept away from sight. The patient then would be required to write the names of objects seen. After everyone completes, the right items in the answer sheet can be ticked while wrong items scratched. The number of correct items is totalled.

At the end of the activity, the Counsellor can give a talk similar to that of last activity. She can also include other factors as selectivity of attention, motivation and methods of information processing in the talk. This would help the patient to learn more about the memory process.

Time Frame

30 to 35 minutes.

Note

The Counsellor does not participate in the activity.

SNAKES AND LADDERS

Purpose

1. To get the members involved in a group.
2. As a part of light recreational group activity.
3. To acquaint members about the 12 steps and key points about recovery.

Materials

The specially made Snake and Ladder Board, Dice and colour chips for participants.

Instructions

Choose your colour chip. You have to roll out a 'six' on dice to start off. Then you can continue in your turn and move that many squares. Your turn will end unless you roll out a six again on the dice. If your chip reaches a square with a ladder, you jump ahead by climbing it. On the other hand, if your chip reaches a square with a mouth of snake, you slide downwards to the bottom of the snake. The first one to reach 100, Happy Sober Life is the Winner. When you reach a square where something is written, please take care to read it. This is what this game is all about.

Procedure

The members are seated around a table on which the Snake and Ladder Board is set. The colour chip for each person is chosen and dice rolled in turns. The chips are moved that many squares as the numbers rolled on dice.

Time Frame

35 to 60 minutes.

Note

The Counsellor does not participate in this activity. The Counsellor should take care to read out the written messages in each square aloud and give one sentence explanation. This would ensure that all of them listen and understand the message. The game should not be discontinued once a member emerges a winner. Other members feel happy when they also finish the game by reaching 'Happy Sober Life.'

REVIEW OF THE WEEK

Purpose

1. To cultivate the habit of taking inventory of events of the day/s.
2. To develop communication by sharing experiences.

Materials

None.

Instructions

There were many events that happened over last week. I would like you to think back what had happened during the week and how you moved through each day (Monday to Friday) of the week. I would like you to share those experiences in the group. Start from Monday. Go through the experiences of the day event by

event. Explain if any thing happened out of the usual, like your getting a good news or you getting tensed up etc. Share what you felt and how if affected you. Similarly go through day by day till Friday.

Procedure

The members share the week's experience.

Time Frame

35 to 45 minutes.

Note

In case any member finds it difficult to share any of the experience in a positive way, the Counsellor can probe and help the member to find a better way with the help of group suggestions. The Counsellor too shares her experience in this activity to bring about genuine sharing on the part of members.

REVIEW OF THE WEEK END

Purpose

1. To cultivate the habit of taking inventory of events of the weekend.
2. To develop communication by sharing experiences.

Materials

None.

Instructions

You have come here after spending your week end at home. I would like you to think back what had happened during the week end and how you spent your Saturday and Sunday. Go through the experience of the week end, event by event. Share with us those unusual experiences, may be mother having a tete-et-tete with you which you never expected or a friend (sober one of course!) dropping in or your people suspecting you having had a drink or smoke. Tell us how you felt and how it affected you.

Procedure

The members share the week end's experience.

Time Frame

25 to 35 minutes.

Note

The Counsellor too participates in the activity. When any member finds himself unable to tackle the experience of the week end, the Counsellor can help the member seeking the group's help (support, suggestion, confrontation, etc., by the Counsellor and also by the group).

STAMP GAME

Purpose

To help members to identify, clarify and discuss feelings better.

Materials

The stamps from 'stamp game' by Claudia Black.

Instructions

Here are some cards of different colours. They are called coloured stamps. Each of these stamps represent feelings.

Red Stamp	:	Any form of anger - such as rage, frustration, irritation, disgust, etc.
Blue Stamp	:	Any form of sadness - such as disappointment, loss, etc.
Black Stamp	:	Fear
Orange Stamp	:	Guilt
Green Stamp	:	Embarrassment
Yellow Stamp	:	Any form of happiness - such as joy, warmth, love, etc.
Light Brown Stamp	:	Confusion
White Stamp (Wild Card)	:	Any feeling not listed above, but the member wants to identify - such as loneliness, helplessness, anxiety, etc.

Please think back and try to remember what it was like when you were a young child or a growing up teenager in your family. As these stamps are only feelings, I would like you to pick up stamps which represent the feelings you had as youngster and adolescent even if you were / were not aware of yourself having these feelings then. You should select a number of stamps representing the intensity of each feeling - for example, if any

one of you had experienced a great deal of anger, you might take 5 to 10 red stamps, compared to feeling of small amount of fear, where you might take 2 to 3 black stamps. You can take 3 - 8 .... to identify with a particular feeling and not required to pick up any particular stamp colour(s) immediately.

(Pause)

Have you all selected your stamps? Now arrange the stamps in an order beginning with the feelings expressed the most as a child, to feelings shown next to the most, to those shown the least. For example, a member who knows that he hid his anger, can find it easier to show sadness and position his blue stamps (sadness) before his red (anger) stamp(s). The person who was afraid and showed that fear will have his black stamp in front of his orange (guilt) stamps, if he seldom or never showed guilt. Thee is no one correct way to position stamps. Arrangement is left up to each one of you. Typical arrangement of stamps could be

Example one:

Most expressed []
[]
[]
[]
Least expressed []

Example two:

Most expressed Least expressed

[] [] [] [] []

Now talk about your stamps with the group. It is easier for you to begin by talking about the feelings you expressed the most, than feeling you had expressed less and so on. When you are telling us, please tell us the source of your feelings rather than simply identifying them. Example - this anger is with my mother for all her screaming Vs. this is my anger (Red). Another appropriate sharing would be the Blues are just for a lot of sadness but I know some of this blue is for feeling sad because my mother and father were out a lot of time, and here are more wild card stamps for the loneliness I felt being left alone so often.

Procedure

The group can either sit on floor or around a large table. After completing the instructions, ask the members to arrange cards. Encourage them to share honestly and openly. As each member shares, other members may become aware of more feelings and may be allowed to quietly add to their piles. While the member is sharing, he may become aware of having more of one feeling than he originally thought and may add to his pile. As the first member has shared his stamps, he can further be asked to reflect on how the stamps are different today as an adult. He can be asked to represent that change by adding to or substracting from his collection and / or repositioning the order. As the member changes his stamps, he can tell the group why he is making the changes. When completed, next person takes his turn. After the last member has shared and if time permits, the Counsellor may

want to ask if the first would like to say more, because the first member is often more inhibited. Thank all the members for their sharing and attentiveness.

It is better if the group end with a quick self-reflection or self-image exercise. Ask the group to express quickly to each other

a) What it is that you are particularly glad you shared?

b) What did you learn about yourself during the game?

c) What did you learn that would be helpful for you to work on?

Thank participants again for being honest.

Time Frame

60 to 90 minutes.

Note

The Counsellor does not participate in playing this game.

VARIATION OF GAME (b)

With Adolescents

The stamp game can be used with individuals or in a group format. While it is not feasible to ask a teenager how his feelings have changed in adulthood, he can be asked to show any change in stamps that would specifically reflect the past year.

ABBREVIATED TOPICS (c)

The stamp game can be used as an integral part of ongoing groups or individual sessions. The member may be asked to

- pick up stamps that represent feelings you had this week.
- pick up stamps that represent feelings you had today.
- pick up stamps that represent feelings you had at school.
- pick up stamps that represent feelings you had with a particular person.
- pick up stamps that represent feelings you would like to discuss.

EXTENDED PLAY (d)

When working with a group or person over time, members may play the game more than once. For the first time it is played without feed back component but later feed back can be included.

Feed back is given after each member has completed sharing his feelings on childhood. To give feedback, other members reflect on what feelings they think the member had or presently has that he did not identify or share. Feedback is given only in the form of offering stamps. To give feedback, other members take stamps from the community pile and place them in front of the member's stamp and briefly explain to the member their perceptions. The feedback given must be specific, limited to 2 to 3 sentences without analysing or intellectualising. The sharing member listens without verbally responding, and acknowledges feedback by picking up new stamps and bringing them into his pile. The feedback cannot be refuted. In case the member is not

comfortable with feedback he can leave it in front of his pile indicating willingness to reflect and consider, but he cannot refuse feedback. There is no dialogue regarding feedback. Thus, it continues with other members and the feedback is ended with a self-image or self-reflection exercise.

The members should know that feedback is optional, not required. Time and member's familiarity with each other are the key factors to consider whether or not this aspect of the game should be included.

UNGAME

Purpose

1. To enhance self expression through the structured game.
2. To begin to establish a norm of sharing and risk-taking in the group.

Materials

The ungame board, playing piece, dice and ungame cards. Papers and pens.

Instructions

This is a self expression game full of light-hearted fun. Each of you select a playing piece and place it on question/comment space nearest to you. After determining who will go first, each one will roll the dice and move in the clock wise direction that many spaces the dice indicates. Any one landing on an ungame would draw a card from the deck, read it aloud and answer in 2 or

3 sentences. The Deck-1 is used in first round and later on Deck-2 is used. None of the members can comment. The thoughts or ideas can be jotted down on a scrap paper and shared when landing on question/comment space. When any one land in this space, that member can ask any other member a question or comment regarding something noted on the scrap paper, something previously shared or anything that comes to his mind or refer to what has been noted on scrap paper. Others will listen without responding. To help you play the game each of you should have a pencil and a paper to jot down personal thoughts and / or questions, to ask other members. When you land on an "If you...." space, the member should read the statement aloud and respond by moving to corresponding "emotion" if it applies to you, or stay on the space if it does not apply. You should share your reasons. On next turn, the member in 'Emotion' area will start his move on the space indicated by the EXIT arrow. When any one lands on choice space, he may choose either to draw a card, ask a question or make a comment. Since this is a self expression game, the group should agree to remain silent except during each one's turn. Similarly, group will listen and understand others when they share and not probe or challenge.

Procedure

The members sit around a large table or on floor. One member is in charge of moving the playing piece. The game is started after instructions are given. The Deck and cards are passed around to the members when they take turn to roll dice so that they can

pull out a card when it is their chance.

Time Frame

45 to 60 minutes.

Note

The Counsellor also participates in the game. The Counsellor is also responsible for the group to listen and remain silent. Since this is a non-competitive game where every body wins, the end can be chosen when there is restlessness noticed in the group or time exceeds more than one and half hours. The game can be wound up into asking each member to reflect about his experience in the game.

GUESS WHAT IS THE WORD

Purpose

1. To introduce structured exercise activities in the group.
2. To raise the energy level of the group.
3. To motivate members to participate in group activity exercises.

Materials

None.

Instructions

Please call numbers 1, 2, 1, 2, 1, 2, 1, 2 .... is it over? Now I would like all the one's to come to my right hand side (Group A) and two's to my left hand side (Group B). Please sit down on

the chairs. Group A would choose a word by group concensus and hold it secret to themselves. One can choose any word under the sun. While Group B would ask questions generally at first and later funnel them down to find what Group A's word is. When answering, Group A would only say 'Yes' or 'No' or 'May be'. Group B can only ask one question at a time. Thus the groups alternate turns.

Procedure

The groups are formed and the game starts after instructions. When the questioning group is able to find out the word, award 1 point. If it is not able to do so, the group which chooses the word, will reveal it to the other group. Then award 1 point to the answering group. Thus 6 - 8 chances for each group are given and points totalled finally.

Time Frame

30 to 40 minutes.

Note

The Counsellor does not participate in this activity.
is.

GARDENING

Purpose

To distract the group with a different activity.

The members are given directions by the Counsellor to work as a group to work in the limited garden space available.

Time Frame

20 to 30 minutes.

TALENT'S TIME

Purpose

1. To bring out the hidden talents of the group members.
2. To give group members an opportunity to develop and exhibit talents.

Purpose

A date is announced to the group and they are asked to exhibit their talents in music, drama, drawing, painting, mimicry, craft, etc., during that time. The hesitant members can be encouraged to participate on the day, as members might be inhibited during the start.

Time Frame

45 to 60 minutes.

INSIDE / OUTSIDE - A DRAWING OF SELF

Purpose

1. To help members to be aware about their perceptions about themselves.
2. To express and communicte their perception's to other members of the group.

Materials

Paper, colour pencils, colour pens, cellotape/board pins.

Instructions

I would like you all to fold the paper given into two so that it becomes a sheet. Now (demonstrate) this is outside and this is inside. I would like you to draw the outside of you, i.e. what sort of a person you are to others. When we look at some one we say he is good, he is bad, he is friendly, etc. Thus how do others find you as a person. On the inside paper I want you to draw the inside of you. The sort of person that you are deep down inside you. You can be open, spontaneous and put the feelings regarding yourself in the paper. This is no competition and so do not expect any one to be artistic and what is expected is only your feelings put in paper as drawings. To give you a clue how to proceed, you can draw through represented pictures of animals, trees, things, etc., or abstractions you can add words to give more depth, but primarily drawing is expected. You can even carricature or scribble. It is entirely left to you. All of you concentrate on your self and drawing. You can take about 20 - 25 minutes to do that.

After 25 minutes are over, the Counsellor says "Now let us sit together in a semi-circle." Please put your works on the board (with either cellotape or board pin) so that we are able to see both inside and outside drawings. I would like you to share the feelings that you have put in the paper to the group. This would

help us to understand what exactly you have meant.

Purpose

The members disperse after the first set of instructions are over. When they finish drawing, the work is exhibited on board. Now the group sits in semi-circle in front of the baord. Each member is encouraged to share. The minor details of the drawing are probed into a non-threatening manner by the Counsellor and the group members. Thank the members for participating and for being honest. End the activity with quick check on the questions of self-image exercise.

Time Frame

50 to 60 minutes.

Note

Since this is an emotionally charged activity, the Counsellor must be warm, understanding and empathetic.

VALUE DEBATE

Purpose

1. To clarify the values, necessary to continue sober and qualitative life.
2. To emphasise that many positive values are needed for maintaining sobriety.

Materials

Four foolscap papers with DISCIPLINE or SELFCONTROL, RESPONSIBILITY, HONESTY, ALCOHOL / DRUG FREE LIFE written on them, cellotape / board pins.

Instructions

You can see four different papers stuck on the wall. Please read them. Also listen when I read what is written on board.

1. Please choose the value(s) that you consider necessary for maintaining sobriety and qualitative life.
2. Explain why you feel that a particular value(s) is necessary to maintain sobriety.
3. Debate with others on your position and try to convince them.

Now you can split and sit around the value(s) you consider necessary.

Procedure

As soon as they get into groups they are asked to settle down and questioned if they feel comfortable with their position regarding values. In case a member expresses that he would like to take up more than a value, he is asked to sit in between to indicate that he is taking an 'in-between' position on the values. After each member explains why he considers his position right, then the group is thrown open for discussion and debate.

Time Frame

45 to 60 minutes.

Note

During debating, the Counsellor guides the group members to argue meaningfully and dwell on issues related to the topic without lingering on irrelevant issues. If a particular member is found to do so, he is confronted and focussed to the particular issue at hand. The Counsellor also intervenes when the atmosphere gets heated due to the debate among the group. During debate, if members feel that they have to change their positions, they are allowed to do so after explaining why they are changing. At the end of the debate, the Counsellor winds up by giving a talk about the need to follow all values, apart from the mentioned ones too, and that only priorities about values shall differ. The Counsellor dispels the misconception that only one value is necessary for maintaining sobriety and qualitative life or that by following one value the other values shall automatically follow. The Counsellor finally convinces those members who are not yet convinced about the necessity to acquire other values.

24 - HOUR - A - DAY DEBATE

Purpose

1. To clarify the concept of 24-hour-a-day to the group.
2. To explain the advantages of following 24-hour-a-day programme to the group.

Materials

Three foolscap papers with '24-hour-a-day' - necessary and possible. '24-hour-a-day' - necessary but not possible and '24-

hour-a-day' not necessary and not possible written on them, cellotape / board pin.

Instructions

Now you see three different papers stuck up. Please listen when I read it. First think to which group you would belong to as regards to your position on 24-hour-a-day. Then explain why you feel so. Finally debate how your position is good or advantageous. Try to convince others to your view point.

Procedure

As members get into different groups, they are asked to explain their view why they have such a stand. Then the group is opened up for discussion and debate. The Counsellor mediates the discussion without allowing it to get into heated exchanges. As members start feeling that their position is not convincing they can be allowed to join a different group. As they get to a different group, they are again asked to explain. Finally the Counsellor winds up with a talk about 24-hour-a-day, its advantages, how it can be followed, what it really means, etc. The Counsellor's role is to convince those who are not yet convinced about 24-hour-a-day and explain the concept.

Time Frame

40 to 50 minutes.

CLAY MODELLING

Purpose

To help group express through the medium of clay.

Materials

Coloured clay. A blunt chisel or knife.

Instructions

I would like you all to work as a group and model this clay rather than each one offering their individual contribution. Discuss among yourself as to what you would like to make as a group. Then start modelling.

Procedure

The clay is provided and a work table is chosen. The group discusses what it will model and starts working. At the end, the group dynamics involved in the particular relationships i.e. interpersonal and itrapersonal relationships are discussed by the Counsellor. The process is done in a empathetic, understanding and non-judgemental atmosphere.

Time Frame

50 to 60 minutes.

GROUP ART WORK

Purpose

1. Using art work in the group as focus to bring about cohessiveness.

Materials

Cards containing following words

Hallucinations	Warden
Cupboard	Anger
Coordinator	Psychiatrist
Attendance	Address
Depression	Personality
Responsibility	Sobriety
Loneliness	Assignment
Feedback	Relapse
Budget	After-effect
Relaxation therapy	Self-pity
Research Foundation	Harmful dependence
Delirium Tremens	Security staff
Esperal reaction	Three months
New comer	Family support
Alcoholics Anonymous	Withdrawal symptoms
Enjoyment of sobriety	Non-smoking area
Getting active physically	Postponing first drink
Fearless moral inventory	Individual Counselling session
Dry drunk syndrome	Changing old routine
Goals for future	Losing control over intoxicants
Loss of self-respect	Committed to change
24-hour-day	Avoiding drinking situation
Community meeting	

Procedure

The game is played with some variations in the rule. The Counsellor has the card with words in the order of number of words in the hand. One of the members is to be asked to come forward from the group and take one card and after reading the word, gives it back. Later, he acts it out to the group and the others identify the word. The group is given 3 chances to identify. If they are not able to identify, a second member is asked to act the word out and the group continues to identify. If still the group is unable to identify the word is read out.

Instructions

One of you is requested to come up and take a card. Please read it. What you are required is to act out the word. You should not talk or move your lips to indicate the word. You can explain the word to the group by gestures and mime. The rest of the group is required to listen and identify what the word is. You can have three chances to identify. If you fail, another person will be asked to act the word out. Okay, let us start. Who would like to volunteer first?

Time Frame

30 to 45 minutes.

Note

The Counsellor does not participate, though all the words are related to addiction, this clue is not disclosed to the group in advance. At the end of the activity, the group can be explained

about the importance of non-verbal communication in individual and social life. How we are using it every day without being aware of our usage, how to sharpen that skill to enhance communication.

ROLE PLAY

Purpose

1. To help the group understand how it feels to be some one else.
2. To better understand others roles and feelings.

Materials

None.

Instructions

Two members from the group will be acting a particular situation before you, watch and listen carefully while they act.

Procedure

The Counsellor selects the role playing problems. She also selects the members of the group who will play each role. The person who plays SELF is made to sit in a highlight position in front of the group. The 'actor' is readied for the presentation of the problem situation. The way to conduct, the dialogues and the mood are explained. Then the actor is asked to act out the situation along with another member who is self. The Counsellor cuts off at a point where the problem has been dramatised, but

the solution or outcome is still uncertain. The Counsellor discusses and analyses the ways in which the actors played roles and better ways of facing such a situation. The next set of actor are readied and the procedure repeated.

Time Frame

45 to 60 minutes.

Note

The Counsellor should effectively discuss the ineffective ways in which the actors played the roles and suggest better ways of coping effectively to such a situation. The solutions should also be addressed to the observing members, as role play sets stage for learning in the members too.

CLAP TOGETHER

Purpose

To focus attention of the group to the group and its leader.

Materials

None.

Instructions

I would start clapping in a particular pattern. The group has to watch out and continue clapping along with me at the same beat. I might suddenly change the clapping pattern and the group should realise the change and change their pattern of clapping according

to my clapping. Another member can suddenly take over the responsibility of leading the clap, by clapping differently. The group should be watching out and notice change of clapping and the lead. The group now follows this member's clapping pattern. Thus the clapping may be altered between persons and clapping patterns too.

Procedure

The group sits in a circle and the leader claps. When the leader changes, the group follows the changed leaders' claps. Thus it continues.

Time Frame

10 to 20 minutes.

Note

When there is excessive confusion over who is leading or about the clapping pattern, the group can be asked to stop for a second and then restart. If confusion still continues, the leader(s) / Counsellor(s) interrupt and can start clapping to end confusion. Then the game continues as usual.

SELF DISCLOSURE

Purpose

1. To provide conducive environment for self-disclosure.
2. To provoke discussion of different self-disclosure of the members.

Materials

The self-disclosure activity questions

1. What is your favourite leisure time interest?
2. What do you regard as your major personality fault?
3. What do you regard as your major personality strength?
4. Do you feel that you have a drinking problem?
5. Do you smoke grass or use drugs?
6. What emotions do you find most difficult to control?
7. What was your worst failure in life?
8. What are your carrer goals?
9. With what do you feel the greatest need for help?
10. What was the greatest turning point in your life?
11. Do you have trouble sharing feelings with others?
12. Do you speak up for your opinions and convictions?
13. Are you as sociable as you want to be?
14. Can you accept compliments without embarrasment?
15. Do things usually turn out the way you want them to?
16. Are you able to set goals and achieve them?
17. Do you know what you are heading for in life?
18. Do you hesitate to try new ways of doing things?
19. Are you getting what you want out of life?
20. Do you feel you have a real purpose in life?
21. Do you feel that you are in control of your life?
22. Is there an area in yourself of your life that you want to change?

Instructions

I would like you to call out the numbers one and two alternatively, so that members could be divided into two groups. The number 1 group should sit in the iside circle and number 2 group sits in the outside circle facing each other. Share the reply for the first two questions with your partner. Then the inside circle members move one chair to their right. Share two more questions with the next partner. Then the outside circle members move one chair to their right. The members now should share two more questions. The same way when I say change, the inside and outside circle members alternate in moving one chair on their right till the self disclosure questions are finished.

Procedure

The self disclosure questions are called out and the members copy. Then they are split into two groups, one inside circle and one outside circle. When the Counseller says change, the inside circle members are asked to change one chair. The next time the outside circle members change one chair to their right and thus the sharing continues. For each sharing before changing the chair, approximatly 3 minutes may be given. After sharing is ended, the members are asked to discuss on the following lines

1. What did it feel to share?
2. How did they feel after sharing?
3. Did any member find any block to share?

Time Frame

45 to 60 minutes.

CHALK GAME

To help members to be aware of the dynamics involved while they are in relation with others.

Materials

Chalk pieces.

Instructions

I would like the group to call out numbers one and two, so that you would split up into pairs. When I indicate 'start', both the members are required to balance the chalk between your index fingers and keep moving for 3 minutes. In case the chalk falls down do whatever you want with it. During the activity you should not talk to each other but experience what the other partner is feeling.

Procedure

The instructions are given and the group starts moving around balancing the chalk. The Counsellor takes note of the leader-follower pattern, their adherence to rule, space covered and their seriousness. At the conclusion of the activity, the Counsellor enquires the members of their feelings when they led, when they were led and what they experienced of partner's feelings. The Counsellor confronts the members of the behaviour which are not shared and brings it to the members awareness. The behaviour manifested in the activity and real life situations are compared and discussed.

Time Frame

40 to 50 minutes.

Note

Since confrontations can be challenging to the member involved, care should be taken to do it in non-evaluative, non-judgemental and understanding manner, lest should the member shrink back into defensive denial system.

TRUST WALK

Purpose

1. To make group members aware of their level of trust in others.
2. To increase the feelings of trust within the group.

Materials

None

Instructions

I would like the group to call out numbers one and two, so that you would split into pairs. When I indicate start, numbers one should lead numbers two. The numbers two should close their eyes through out the walk. The pairs must not talk to each other or lead by touch. You can devise a communication style which will help you to lead each other. You will keep walking for 3 minutes and then change positions. The member who lead would now follow. The same rule of closing eyes, no interaction and no touch also applies now.

Procedure

The instructions are given and the group starts moving for 3 minutes. The Counsellor takes note of space covered by members, their seriousness, their adherence to rule of the game, the leader-follower pattern etc. The members change positions and the pattern is again taken note of. At the conclusion of the walk the Counsellor enquires the members of their feelings when they led when they were led and what did they feel towards their partner. The Counsellor now gives feedback and brings into member's awareness of the facts he did not notice while he participated. The relation of behaviours during activity and the real situational reactions in life are compared and discussed.

Time Frame

30 to 50 minutes.

Note

Since confrontations can be challenging to the member involved, care should be taken to do it in a non-evaluative, non-judegemental and understanding manner, lest should the member shrink back into defensive denial system.

'T' PUZZLE

Purpose

1. To make group members to be aware of their motivational level.
2. To help member to build a positive attitude towards problem solving.

Materials

The broken 'T'cut from stiff board.

Instructions

I would like each of you to put the broken pieces together so that the pieces form a whole T. You can take as much time as you want.

Procedure

The members are given the piece of 'T' and are asked to assemble them into a letter 'T'. The Counsellor takes note the verbalisations, the motivation to work, the attitude towards work, the problem solving method, response to frustration etc. during the activity. At the conclusion of activity the members are checked on their feelings during the activity. The Counsellor then gives the feedback about the observations made and confronts the member in case he does not agree. The activity is wrapped up by enquiring each member about his experience in the activity.

Time Frame

45 to 60 minutes.

Note

Since confrontations can be challenging to the member involved, care should be taken to do it in a non-evaluative, non-judgemental and understanding manner, lest should the members denial system be re-awakened to form strong defenses which would

block positive growth. The Counsellor can finally summarise the ineffective problem solving method found in the group and contrast it with the effective problem solving method.

REVIEW OF PATIENT'S STAY BY OTHER MEMBERS

Purpose

1. To give feedback to the member about how others see them.
2. To give member a chance to reflect on different skills he had learned during the stay.

Materials

None.

Procedure

A member is chosen to be given the feedback and he and other members are informed two days in advance. The member receiving the feedback, sits in 'highlight' position before the group. The others give their feedback to him on the selected areas. After the feedback, the member in 'highlight' too reflects on his experience in the centre.

Instructions

As you all know, we have (name's) review of his stay. You all can give your feedback to him. I would like the feedback to be genuine, honest, precise and specific on the areas listed on 'the board.'

The Areas

Physical

Health

Physique

Personal grooming and hygiene.

Family

Relationship with family members

Involvement in family duties

Social

Relationship with others / friends

Gain in new positive friendships

Development of new hobbies, interest and other social activities.

Occupational

Job

Involvement in the job or to find a new one

Values

Sincerity

Personality

Honesty

Acceptance

Involvement in p ogramme

Maturity

Ability to solve / face problems

SHAME

Understanding and Coping

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Part I: Understanding Shame

Part II: Coping with Shame

Introduction

Recovery from active alcoholism is simple. You just don't drink — that is, you stay away from the first drink, one day at a time. Living as a sober alcoholic, not only maintaining sobriety but progressing in recovery, can prove a bit more complex.

As usual, among those who try to live the program of Alcoholics Anonymous, let me start off by saying sincerely that I write these pages for my sake — to help me stay sober. I hope what you read will help you in your sobriety.

My real name is irrelevant, but I am an alcoholic. Also, toward the end of my drinking, I popped quite a few pills — all legally prescribed, although not all honestly obtained from the trusting doctors I made a hobby of conning.

It wasn't a difficult hobby. We alcoholics develop considerable skill at conning, what with all the practice we get conning ourselves. Besides that, I am one of those over-educated, professionally trained alcoholics who can talk in psychology. Doctors have a hard time labeling us "alcoholic" — about as hard a time as we have ourselves. "Denial" is no respecter of degrees.

Over time, the mounting dishonesties in my life caused it to fall apart. Alcohol and other chemicals no longer killed the pain. In fact, I dimly came to realize that they were adding to it. During my fourth admission for detoxification, a caring physician, a street-tough cop, and a respected clergyman friend all "suggested" treatment for chemical dependency. Having nowhere else to go — my employers and my living companions had both strongly indicated that they would just as soon never see me again — I graciously consented to use the airplane ticket to Minnesota that a former employer generously provided in lieu of severance pay.

For someone so smart, I learned a lot in treatment: complicat-

ed concepts like "Easy Does It" and "First Things First." I also absorbed a few things that didn't come packaged in such neat maxims, and it is one of these that I hope to share with you in this booklet. My story reveals that the pain of dishonesty, the trauma of knowing I was not the person I pretended to be and was *supposed to be*, lay at the core of my alcoholism and addiction. After all, who ever heard of a professional person, with degrees and even titles, *needing* a drink?

Fortunately, I met others like me in treatment. And even more fortunately, the first important thing I discovered was that they were "like me" not because of the degrees and titles — some didn't have them — but because they *hurt as humans*. An alcoholic mother or a pill-popping wife or any of a hundred other kinds of people in a thousand different situations can hurt and ache and wrench and clutch inside just as I did — and then can get caught in the trap of trying to soothe that pain with chemicals such as alcohol.

Some people, I learned, can do that — soothe the pain — and get away with it. They seem not to have the physical metabolism or the "physiological x" or the *whatever* that is somehow a part of those of us who become alcoholics. For a brief time, I envied such people. My "Why me's?" oozed self-pity until one crisp fall day as I walked privately, sensuously absorbing the beauties around me, a new — truly sober — way of thinking gently insinuated itself into my mind and feelings.

"Why me?" indeed! Why should I be one of the lucky ones to see the vibrant colors of autumn leaves through unhazed eyes? To hear the breezy rustle of those leaves punctuated by chipmunk chirps and the lap of the waves on the lakeshore and the resounding calls of migrating waterfowl? To smell the clean fall air with its scents of apples and wood-smoke and of the furrowed and harvested good earth preparing for its winter sleep? To feel on my face the occasional sting of a gust of wind — was that an early snowflake that just pinched my cheek? — and the resilient, grassed path under my feet and the gnarled bark of the wise, aged trees that I rub against in passing. Why should I be one of the lucky ones able to stand before and within all this beauty, to drink it in with *clear* senses, able to confront and to appreciate reality as it is without a curtain of chemicals? Indeed, "Why me?"!

They told me something interesting in treatment: there is a difference between getting sober and staying sober. I pegged my memory of that warning — of that *promise* — on some words of Bill Wilson, co-founder of Alcoholics Anonymous. "Honesty gets us sober but tolerance keeps us sober," Bill once said. Over the years, I have hung a lot on that phrase. But especially, I hang on it whenever I catch myself feeling bad.

In treatment and in early sobriety I began to learn quite a few things about feeling bad. I learned that there were some kinds of feeling bad that I never had to go through again. The physical side, the terrors of withdrawal, headed that list; but it included the worries about behavior during blackouts and other misbehaviors fueled by alcohol. What a simple, liberating truth it was to know that if I didn't drink, I wouldn't get drunk!

Yet there was more to learn about feeling bad. Growing sobriety taught, for example, that there is a vast difference between *feeling* bad and feeling *bad*. That is not, believe me, just a play on words. *Feeling* bad means hurting. The active alcoholic experiences myriad ways of *feeling* bad.

Feeling *bad* is something else. In fact, as we shall see, it is two things else. Feeling *bad* means feeling that there is something wrong with me, about me. One thing I had to learn was that feeling *bad* is different from *feeling* bad, and there are two different kinds of feeling *bad*. Until I learned to tell them apart, getting and staying truly sober was a lot harder. In fact, for me, staying sober at all seemed nearly impossible.

There were two ways, I learned not so quickly, in which even the non-drinking alcoholic could feel *bad*. And until I learned to sort them out, learned to handle each one differently, this non-drinking alcoholic was never able to find even the semblance of true sobriety. There was, I discovered, a real and significant difference between the feeling *bad* of *guilt*, and the feeling *bad* of *shame*. "Guilt" concerned what I *did*. "Shame" was about what I *was*. And there's more: let me try to tell you about it.

Part I:

Understanding Shame

Shame, Guilt or Embarrassment

Shame differs from guilt. For one thing, it is a more troublesome feeling to confront and relieve. Facing up to guilt — the things that we *do* — although it can be painful, is not really difficult. The beginner in Alcoholics Anonymous, for example, finds guilt eased by A.A.'s very First Step, in the admission of powerlessness and unmanageability. As recovery progresses, the alcoholic finds further help in dealing with guilt in the inventory and amendment Steps of the A.A. program. Especially A.A.'s Fourth, Eighth, and Ninth Steps guide us directly to the resolution of guilt.[1]

Facing up to shame — to what we *are* — proves more tricky and, for most of us, more difficult. As with guilt, Alcoholics

Anonymous suggests a solution for shame.* That solution is anticipated in the admission of powerlessness and unmanageability. Steps Five, Six and Seven start the process of resolving shame.[2] But it is Alcoholics Anonymous as a *fellowship* that makes the solution real. I hope, in what follows, to show how; but, first, it is necessary to spend a few moments thinking and talking about those words, "guilt" and "shame."

Neither word is used much nowadays. "Guilt" seems mainly a technical term, used appropriately only by psychiatrists and lawyers. Our modern age so mistrusts any whiff of moralism that most people have become uncomfortable with the term "guilt." "Shame" labors under a different disability. Generally reserved for training children and animals, it suffers mightily from this association with helpless dependency. "Shame" carries echoes of being caught; and, of course, no truly mature person is ever naughty.

Such an understanding of shame contains a trap. I used to think that shame was the same as embarrassment, that it resulted from being seen or caught by someone. As children, we are told to be ashamed of ourselves when we are caught publicly. But even as children, shame results not from being *seen* doing something, but from *what* we are caught doing! Embarrassment, therefore, is not the same as shame, but is the result of one's *shame* being seen.

In my home A.A. group, one oldtimer — a seasoned alcoholic literally grizzled and occasionally crass, but filled with the deep and loving wisdom that comes from long and joyous sobriety — once suggested a thought that, although it offended me at first, made a point that for the sake of my sobriety it seems I had to hear. According to Ben, the words themselves help you

*The opinions expressed are solely those of the author and do not represent A.A. as a whole.

to tell embarrassment from shame. "Embarrassed" means being caught "bare-assed." "Bare" means uncovered, and therefore *seen*, but it is *what* is seen, one's *derriere* — the testimony to one's *shame* — that causes embarrassment. "Bare-faced," Ben liked to point out, means the exact opposite of "embarrassed."

As I said, I didn't like Ben's image when I first heard it, but over time I discovered in it a deep wisdom that I now find helpful in handling my shame. For now, let's nail down this important distinction between shame and embarrassment by noting that the sense of shame comes before any sense of being seen by another. Our shame exists in us, in ourselves — indeed, in our very *self*, which is why shame is so important to the discovery of who we *really* are. Other people do not cause our feelings of shame. Rather, as we shall examine in later chapters, in a strange quirk that reveals the treachery of confusing embarrassment and shame, we learn in A.A. that others provide the only true therapy for the discomforts and agonies of shame.

So much for the distinction between shame and embarrassment; now to the difference between shame and guilt. Both guilt and shame involve feeling *bad* — feeling *bad* about one's *actions* in the case of guilt; feeling *bad* about one's *self* in the experience of shame. "Picture a football field," I was once told by a well-meaning counselor, "with its two kinds of boundaries: sidelines and endlines. The sidelines are *containing* boundaries: to cross them is to 'go out of bounds' to do something wrong. The endlines are *goal lines:* the purpose of the game is to attain them and to cross them. One feels guilty when one crosses the sideline, the restraining boundary. Feeling bad about the goal line (shame) arises not from crossing it but from *not* crossing it, from failing to attain it."

As a child, I habitually played hooky on test days: it seemed safer to do the wrong thing of skipping school than to risk falling short. The guilt of playing hooky pained less than the possible

shame of not measuring up on the tests. That does seem like alcoholic behavior, even without alcohol, doesn't it? In any case, in later years, I would do many similar things — *with* the help of alcohol and other chemicals.

Guilt, then, arises from an infraction, a violation or transgression of some "rule." Shame, on the contrary, occurs when a goal is not reached. Shame indicates a literal "shortcoming," a lack or defect of being. This little chart may help clarify:

	GUILT	SHAME
Results from:	a violation, a transgression, a fault of *doing* the exercise of power, of control	a failure, a falling short, a fault of *being* the lack of power, of control
Results in:	feeling of wrongdoing, sense of wickedness: "not good"	feeling of inadequacy, sense of worthlessness: "no good"

A chart is neat, but examples sometimes prove more helpful. When I cheat, or steal, I do something wrong and feel *guilt* over this violation of the rights of another. But also, on at least some occasions, my cheating or stealing can inspire *shame*. When my son got a job and worked on his own all summer to save money for college and clothes, what kind of person was I that I stole from his savings to buy booze I could hide from the family budget? Especially when it became clear that the "few dollars" I thought he'd never miss turned out to be almost half of what he had earned?

Stealing a physician's prescription pad is against the law. I knew that, but it didn't bother me much, because I had worked out a foolproof way of using those precious, powerful pieces of paper. What kind of *person* was I to do such a thing? I mean, I was acting like a junkie! Was I just a junkie? I thought up a thousand reasons why not, why I was *different*, but the nagging, gnawing thought and fear burrowed deep into my mind and never left me until I confronted that question in treatment.

Not long ago, one of my pigeons called and asked, sort of desperately, to talk with me — suggested that we go to a meeting together and then have coffee or even, since we hadn't talked lately, maybe meet for dinner before the meeting. Now, I was planning to go to that meeting, and I like Sandra. But I was hoping to go to that meeting for *my* sake. I had even thought, earlier in the day, before she called, how nice it would be to go to that small, quiet meeting — one at which I generally do not meet any of my pigeons.

Now obviously, when Sandra called I should have told her how I felt — should have admitted my own needs. But I didn't. The old alcoholic need to be perfect, the need to be thought perfect, welled up; and almost without thinking I reeled off a cock and bull story about how, despite my great fatigue and overwhelming professional obligations, I had to reach out, that very evening, to a co-worker who was obviously having trouble with booze.

Never mind Sandra's obvious disappointment (why is it that our A.A. pigeons seem to read us so well?); never mind even my rapidly drying mouth as I realized that my voice was getting higher and my words spilling out ever faster — a sure sign, for me, of dishonesty. Let's focus on the guilt and shame. Guilt: I was, in a sense, breaking a rule. Oh, there are no "rules" in A.A., but I had been taught about gratitude, and about the responsibilities of sponsorship, and besides that, I was lying. In several ways, then, according to my standards, I was doing wrong. But what nagged at me and hurt most and confused me desperately was what I had revealed about my sobriety, about *me*. Even before my hand finished replacing the telephone on its cradle, the ball of hollowness that was beginning to expand in my stomach forced me to confront my shame. Was this sobriety?

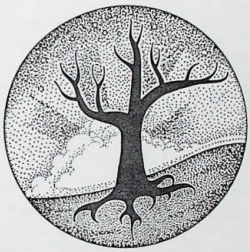
How real was my sobriety, what kind of recovering alcoholic was I, if I could so easily, glibly, almost thoughtlessly lapse into such obviously alcoholic dishonesty?

The point here, of course, is that guilt and shame are distinct: there was a difference between knowing that I had done wrong and feeling that something was wrong with me. In these examples, guilt and shame come mingled. But before we turn to examine that mingling more closely, let me finish my little story, for its end does tell something about A.A. and shame.

I called Sandra back and, without attempting an explanation, arranged to meet her and go to that meeting. Over coffee, I told her the truth: that I had lied, and how that had led me to question my own sobriety, and that she clearly had chosen a very non-perfect sponsor. Sweet Sandra! She calmed my guilt by very seriously and carefully reminding me that "there are no rules in A.A." And then, without realizing it, she spoke to and touched and soothed my shame. "I felt your rejection, and it hurt me; and even when you called back, I wasn't sure. It still hurt, and I was almost afraid you were calling back because you felt you *had* to, had to at least go through the motions. How marvelous that you're not perfect, that you are human! I wouldn't have any other kind of sponsor!" She said more, but I hugged those words close and I want to share their warmth with you now: how marvelous it is to learn, as alcoholics, that we are human — that we are not perfect, and that it is our very lack of perfection that makes us valuable to others. Experiences of shame are valuable because they teach and remind us of that very important — and very happy — reality.

It is sometimes difficult to deal with shame because experiences of shame come mixed with parallel feelings of guilt. My son's money, my doctor's prescription pad, my dishonesty with my pigeon: in each case there was guilt over wrongdoing, but concentration on that guilt would have missed the main point. I stole from my son, but I could make restitution. I broke the law, but I could stop breaking it. I lied, but I could confess the truth. However, in no case would those amends, although necessary, have been sufficient to touch and to heal my *shame* — to help me know and live with the "real me." To get sober, I had to deal with the "What kind of person?" question buried in those episodes. To stay sober, I also had to confront such questions as: "What kind of sponsor?" "What kind of sobriety?" "What kind of member of A.A.?"

Making that separation, exploring its significance, and building on its foundation are the tasks of the next chapter.



Shame and Being Human

Although guilt and shame are different, they often come mingled. Guilt, especially, rarely occurs alone. Most of the time. a wrongdoing also involves falling short or failing to live up to your ideals. When I stole, for example, I not only did wrong, I also fell short of my ideal of honesty. Although it does not always happen, one can feel shame and guilt over the same thing — the same act triggers both kinds of feeling.

When this happens, distinguishing between guilt and shame *and responding first to shame* is essential to the development and maintenance of quality sobriety. Guilt and shame are accented differently. Feelings of guilt place emphasis on the act committed: "How could I have *done that?*"

Shame, on the other hand, focuses on the person who committed the act: "How could *I* have done that? What an idiot *I* am! How *worthless* I am!"

Resolving guilt is important: that is why the Eighth and Ninth Steps play such an essential role in recovery. But confronting shame is more important because it is shame far more than guilt that lies at the root of our alcoholism. And our alcoholism itself, if we stop to think about it and have learned anything about it, involves much more a *falling short* than any sort of transgression. I denied my alcoholism for so long, not because alcoholism was a bad thing, but because admitting that I was an alcoholic would have meant acknowledging that I was a bad person.

The first truth that A.A. teaches us concerns the reality of our personal limitation: "We admitted we were powerless over alcohol — that our lives had become unmanageable." The first thing we learn in Alcoholics Anonymous (and how welcome a lesson it is!) is that A.A. is concerned not with the thing, alcoholism, but with the person, the alcoholic. A.A. thus speaks to and touches our shame in its very First Step. The acknowledgment "I am an alcoholic" contained in the admission "powerless over alcohol" invites us and *frees* us to accept the truth of our essential limitation. Newcomers to Alcoholics Anonymous thus come to admit, to accept, and even to embrace essential limitation as the *definition* of their alcoholic (human) condition.

The acceptance of essential limitation is the core and the heart of Alcoholics Anonymous. This acceptance, indeed, becomes both the price and the reward of our First Step admission: "powerless over alcohol." By this emphasis on essential limitation, Alcoholics Anonymous teaches us a profound and healing truth: accepting the reality of self-as-feared is necessary to finding the reality of self-as-is. Learning this truth enables us to begin on the road to sobriety. Building upon it becomes, in sobriety, equally necessary to progress and grow.

As we grow in sobriety, we must remember this first lesson; but if we truly *grow* in sobriety, we also come to see that our alcoholism is not our only essential limitation. We learn, within Alcoholics Anonymous, that our fundamental limitation is not that we are alcoholic, but that we are *human*.

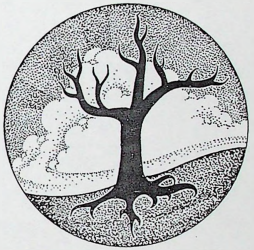
Alcoholics Anonymous as a way of life builds on our alcoholism to teach us that to be human is to be essentially limited. We exist in a contradiction, between opposite pulls to be more-than-human and to be less-than-human. The idea should be amply familiar to us from our days of active alcoholism. We drank, often, in an effort to be *more* than we were: more witty, more relaxed, more charming, more *whatever*. And the result of that effort, once we became alcoholics, was inevitably the opposite: we got sick, or passed out, or made fools of ourselves, or in any of far too many ways concluded our drinking far *less* than the human beings we were before we turned to alcohol.

At other times, perhaps, we drank in the effort to be "less-than-human": we drank to be less inhibited, less awake, less feeling, less aware. The result of those efforts was inevitably to heighten the sensibilities we had hoped to diminish, wasn't it? We perhaps shed an inhibition, but we became acutely sensitive to imagined insults. Or we found ourselves less sleepy than ever, aware of even the slightest sound. Often, the pain we tried to escape became intensified by the very drugs we took seeking relief. Remember when?

Blaise Pascal said, "He who would be an angel becomes a beast."[3] The attempt to be more than human leads to being less than human. Another thinker, George Santayana, suggested a related observation: "It is necessary to become a beast if one is ever to be a spirit."[4] That is, in order to know the heights of human existence, one must also touch its depths.

Together, these understandings summarize the heart of what Alcoholics Anonymous teaches us about being human — about

being "a god who shits."[5] In the A.A. diagnosis, active alcoholics drink in the attempt to be *either* an angel *or* a beast. Sobriety means accepting the reality that we are *both*. Acceptance of this reality of being human comes easily to the alcoholic who understands alcoholism, because the condition of alcoholism mirrors the essence of the human condition.



Shame and the Non-moral

(Love, Sickness, Freedom and Reality)

Three characteristics of shame help us come to terms with its painfulness: 1) shame can arise over a *non-moral* failing; 2) it tends to be occasioned by an *involuntary* shortcoming; 3) it seems magnified by the very *triviality* of its stimulus. These qualities aid in distinguishing shame from guilt and shed light on the nature of the essential limitation that Alcoholics Anonymous teaches us lies at the core of the human condition.

Guilt, you may recall from our earlier discussion, arises from the violation of some restraining boundary. This implies that guilt characteristically has to do with moral transgression, results from a voluntary act, and tends to be proportionate to the seriousness of the offense committed. Guilt thus follows from a wrong that

one chooses to do; and the graver the wrong, the greater the guilt.

Shame differs from guilt on all three counts, even when both arise together after a wrongdoing that marks also a falling short. We will come to understand shame best, however, by separating these qualities that characterize it and by examining cases of shame uncontaminated by guilt. The next two chapters will examine shame's connection with the involuntary and the trivial.

Although shame may arise over a moral lapse such as stealing, some of our failings have nothing to do with morality. Two such cases seem especially important for us to deal with as alcoholics: failure in love and the failure of sickness.

Love

Perhaps the most common source of non-moral shame, and not only for alcoholics, is disappointment in love. But especially for alcoholics, such shame can be particularly dangerous. How many times have we turned to alcohol out of the frustration of feeling unloved or rejected? Guilt over wrongdoing plays no role in such cases; we seek rather the solace of the bottle in the attempt somehow to warm or to fill the chill, hollow emptiness of felt inadequacy.

Defeat, disappointment, frustration, or failure evoke shame. Guilt, as transgression, always involves aggression: one feels guilty about the aggression. Shame arises over the failure — or the foolishness — of the attempt, rather than over the attempt itself.

Shame arising from failure in love can haunt the alcoholic drinking or sober. Being "passed over," failing to win a hoped for and sought after raise or promotion, can wound painfully. Defeat and disappointment, frustration and failure, haunt the *human* condition. As active alcoholics, our disadvantage on such occasions was that we had a cop-out that inevitably made

things worse. Our advantage as recovering alcoholics is that we know what it is to be human, and we have learned to find solace even in our hurt, for that hurt proves that we are human, whereas once we very nearly were not.

Sickness

Painful as is the shame of failure in love, the failure of sickness can be worse. To be ill is not to transgress, to *do* wrong, but to fall short, to *be* lacking. Health is the norm: we naturally feel that we should be healthy. Lacking health, we feel that there is something wrong not only with us, but about us. Being sick implies inadequacy.

We need to think about that, for both the disease concept of alcoholism and A.A.'s emphasis on alcoholism as malady serve two functions. They remove alcoholism from the category of morality and thus render us less guilty; but they also firmly locate us as alcoholics in the shameful situation of being chronically ill. Alcoholics Anonymous, in emphasizing that alcoholism is malady rather than sin, also proclaims that there is a difference between the guilt feeling of wickedness and the shamed sense of worthlessness. A.A.'s experience — *our* experience — teaches clearly that the alcoholic's problem is not that he is wicked, but that he feels worthless.

The feeling of worthlessness is worse than the sense of wickedness. How, then, does it mark progress in therapy to label alcoholism a disease? Does it not rather render the plight of us poor alcoholics even more pitiful and hopeless, if it means exchanging guilt for shame? It might seem so, except that the experience of over a million members of Alcoholics Anonymous clearly testifies that "It Works!"

Freedom and reality

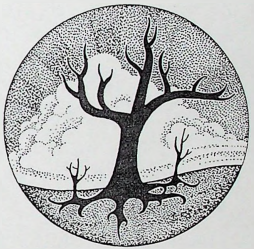
It works because it teaches reality, and the first truth of human reality is that we are limited. Alcoholics Anonymous understands the deep danger to sobriety of the alcoholic's tendency to demand "all-or-nothing." A.A. therefore teaches us, as recovering alcoholics, not only the *fact* of our limitation and our *need* to accept it, but also the positive side of that limitation and its acceptance. There is an equation — a necessary connection — between being limited and being real. We see this most clearly in the matter of *freedom*.

The drinking alcoholic turned to alcohol in search of freedom; the recovering alcoholic searches for freedom from alcohol. The experience of Alcoholics Anonymous teaches us that the second search will prove as vain as the first, unless we accept the simple truth that to be human is to be *both* free and unfree. For the alcoholic, as for any other human being, there is no absolute freedom.

As recovering alcoholics, we learn first in Alcoholics Anonymous that our freedom, *although* real, is limited. Conversely our freedom, *although* limited, is real. To attain the freedom to not-drink, we accept limitation of our freedom to drink. In recovery we must come to see that this acceptance is not a concession. The word "although," must be replaced in our thinking by the affirmation "because": *because* real, our freedom is limited; *because* limited, our freedom is real.

A.A. experience continually reminds us, as recovering alcoholics, how the apparently unlimited freedom to drink inevitably leads to increasing bondage and ever greater losses of freedom. Some of us, in defending our "freedom" and "right" to drink, lost jobs and status, wealth and love and more; some, we know, lost life itself. The same A.A. experience progressively reveals, on the other hand, how the limited freedom to not-drink brings in its wake ever-increasing freedom.

As recovering alcoholics within Alcoholics Anonymous, we thus learn a profound truth: with freedom, as with any other human phenomenon, to be real is to be limited, for limitation *proves* reality. This understanding enables both joyous acceptance of the human condition and true recovery from alcoholism. It enables both because that acceptance and recovery are one and the same.



Shame and the Involuntary

(Problems of Willing)

Guilt implies choice. Shame, on the other hand, occurs over something involuntary: it arises from *incapacity*, from the *failure* of choice. The memories of car accidents, of tumbles down stairs, of food or drink spilled on friends or guests, remain painful well into sobriety. Of course we didn't "choose" to do those things — they were clearly involuntary, but can't those memories still sting?

The pain in shame arises from the failure of choice, of will, of *self*. A married man who committed adultery might feel both guilt and shame: guilt over the violation of the marriage promise: shame at falling short of the marriage ideal. The man who finds himself sexually impotent with a woman he loves will feel

predominantly shame: the question of morality does not enter, and surely such sexual disability is anything but voluntary.

When a drinking alcoholic asks "Why?" — "Why do I drink; I know I don't want to!" any sober alcoholic who knows and lives the philosophy of Alcoholics Anonymous knows better than to try to prove that he really did want to. The A.A. answer accepts involuntariness: "You didn't want to, but you did. You did because you are an alcoholic. That is what an alcoholic is: one who drinks when he doesn't want to. The answer to 'Why?' lies not in your will, in its strength or its weakness, but in the fact that you are alcoholic."

The involuntariness of shame is important because we learn from it something about the human will and its limitations. The alcoholic cannot will to not-drink any more than the insomniac can will to fall asleep. The example is exact: in each case, we can will the means, the context that will enable the desired end to come about; but also in both cases, any attempt directly to will the end — any effort to seize the object desired — proves self-defeating.

There are two very different ways in which we attain two different kinds of things that we will. In some matters, we choose particular objects: I can choose right now whether to write in pencil or with pen, whether to keep writing, or to refill my coffee cup, or to go for a walk. In other matters, we choose an orientation, a direction, a context that will allow — we hope — our end to be achieved. I choose right now to sit at this desk, with good light and away from distractions, and to rehearse in my mind the many things I have learned at meetings of Alcoholics Anonymous. But I cannot will, as I will to use this pen, either brilliant thoughts or that you — one particular reader — understand my point here. Indeed, were I to attempt to will either, the writing would cease, for the very effort would overwhelm me and become a "block."

We get into trouble with willing when we try to will directions, contexts, in the same way that we will to choose objects. There are some contexts that vanish under such attempts at coercion. I cannot will sobriety, but I can choose not to pick up the first drink, today. I cannot, over any length of time, will to not-drink; but I can choose to go to A.A. meetings and to work on the Steps of the A.A. program. If I should try to will sobriety in the same way that I choose to pick up the telephone to call my sponsor, I would be drunk within a week. If I should try to will to not-drink in the same way that I choose to get in my car to go to an A.A. meeting, my track record before finding Alcoholics Anonymous offers ample proof that I'd be getting in my car to go out to buy booze.

And all this is true not only of things having to do with drinking and sobriety. I can, right now, will to write vividly, but not directly that you continue to read. I can will knowledge, but not wisdom; submission, but not humility; self-assertion, but not courage; physical nearness, but not emotional closeness.

Because shame so often arises from the failure of the effort to will what cannot be willed, experiences of shame contain an important lesson for us as alcoholics. To know shame is to realize that certain things fall outside the reach of what we often think of as "will," beyond the scope of the manipulative will that chooses objects. Sobriety, wisdom, humility, courage and love are not objects: we can choose to move toward them, but any effort to seize them runs the self-defeating risk of destroying them. Again, recall the promise of Alcoholics Anonymous: "progress rather than perfection" — movement toward rather than absolute possession.

To be human is to be limited, and because our human will is especially limited, there can be no absolutes or unlimitednesses within our human power. Alcoholics Anonymous inculcates this truth by clearly directing our attention to the two areas in which

the alcoholic seeks, by using alcohol, to deny the limitation of the will. These two areas are control and dependence.

Limited control

Drinking alcoholics, we learn if we listen carefully at meetings of Alcoholics Anonymous, drink alcohol in an effort to achieve control — *absolute* control — over their feelings and their environment. Whether we drink to feel "high" or to relax, to make us witty or to soothe our pain, we drink to control. In drinking to control mood, we attempt to deny that our moods depend upon situations — and especially upon people — outside ourselves, beyond our control. We drink in an effort to deny such dependence; yet, in this effort, our dependence upon alcohol itself becomes absolute.

The alcoholic's problem, then, involves the demand for unlimited control and the denial of real dependence. The fellowship and program of Alcoholics Anonymous meet this double problem in a twofold way. First, A.A. confronts us as alcoholics with the plain facts that, so far as alcohol itself is concerned, we are absolutely out of control and absolutely dependent. Then, after we accept this reality by the admission "powerless over alcohol," Alcoholics Anonymous both prescribes and teaches the exercise of *limited* control and *limited* dependence.

The Seventh Step of the A.A. program originally began with the words, "Humbly on our knees. . ." Kneeling is a middle position — halfway between standing upright and lying flat. In a sense, Alcoholics Anonymous understands the alcoholic to be someone who, by claiming absolute control and denying all dependence, insists on trying to stand upright unaided, only to fall repeatedly flat on his face — often literally in the gutter. To the alcoholic lying prone, A.A. suggests: "Get *up* on your knees — you can do something, but not everything." Later, as we progress toward sobriety, A.A. often has occasion to temper our tendencies to grandiosity with a similar suggestion: "Get *down* on your knees — you can do something, but not everything."

A.A.'s emphasis on limited control runs through its whole program. Think about that encouragement combined with the admonition, "You can do something, but not everything." We are warned against promising "never to drink again" and taught instead how not to take the *first* drink, "one day at a time." We learn to reach for the telephone instead of the bottle. A.A. encourages us to attend meetings, something we can do, rather than to avoid all contact with alcohol, which is virtually impossible. For me, the whole point of limited control is beautifully summed up by the Serenity Prayer: "Grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

The "can" and "cannot" of the Serenity Prayer remind me powerfully not only of the limitations on my ability to control, but also of how as recovering alcoholics we owe our priceless possession of freedom to the fellowship and program of Alcoholics Anonymous. As we learn in A.A., alcoholism is an obsessive-compulsive malady: the active alcoholic is one who *must* drink, who *cannot* not-drink. Thus, when we join A.A. we do not surrender any "freedom to drink"; rather we gain the freedom to not-drink. I sometimes think, indeed, that within Alcoholics Anonymous our passage from "mere dryness" to "true sobriety" is marked precisely by that change of perception. We begin, as each of us must, by "putting the cork in the bottle." We start by accepting the prohibition, "I cannot drink." But somewhere along the line, if we work the Steps and live our program, we come to see that that acceptance is not primarily a prohibition, a negative. Our life in recovery discovers the joyous affirmation behind that apparent restraint, and we begin to

rejoice in this happy new reality — in the *real* freedom of "I *can* not-drink."

Limited dependence

This understanding of human freedom suggests not only "limited control," but also "limited dependence." The dead-end trap in which active alcoholics are mired consists of *two* denials: their denial of dependence upon alcohol is but one manifestation of their larger denial of dependence upon *anything* outside themselves. Alcoholics turn to alcohol *inside* themselves in order to enforce that denial of dependence.

In confronting this dual denial, Alcoholics Anonymous subtly challenges a frequent modern assumption. Other therapies tend to approach alcoholics from their own point of view — to agree that all dependence, but especially *essential* dependence such as that which binds alcoholics to their chemical, is humiliating and dehumanizing. They try to convince the alcoholic that maturity and "recovery" — becoming fully human — mean overcoming all such dependencies. Diagnosing alcoholism, virtually all modern therapies see the alcoholic's problem as "dependence on alcohol," and they endeavor to break the alcoholic's dependence.

The larger-wisdomed insight of Alcoholics Anonymous does not exactly contradict this understanding. Indeed, A.A. agrees with and accepts this diagnosis that the alcoholic's problem is "dependence on alcohol." But Alcoholics Anonymous penetrates deeper, locating the definition's deeper truth by shifting its implicit emphasis. A.A. interprets the experience of its members — *our* experience — as revealing that the alcoholic's problem is not "*dependence* on alcohol," but "dependence on *alcohol.*" To be human *is* to be limited, Alcoholics Anonymous insists, and therefore to be dependent. The alcoholic's choice — the *human* choice — lies not between dependence and independence, but between that upon which one will acknowledge dependence: a less than human substance such as alcohol within oneself, or a more than individual reality that remains essentially outside — beyond — the self.

Shame and the Trivial

(The Exposure of Denial)

The third and final characteristic of shame to be examined is the frequent triviality of its source — the apparent disproportion in shame that makes it literally such a monstrous experience. Usually, when we feel guilt, the intensity of our guilt is proportionate to the gravity of our offense: the more serious the transgression, the greater the guilt.

Shame, on the contrary, tends to be triggered by the most trivial of failings, by some small and even picayune detail. This happens because such little things point unmistakably to the failure of self *as self*, rather than as breaker of some rule. The employee who embezzled a thousand dollars, when he comes to doing his Eighth and Ninth Steps, feels mostly guilt. The person

who has cadged quarters off a co-worker's desk or consistently ignored the office coffee pot's plea for coin contributions, feels more shame than guilt. If we can tap that shame, can touch that triviality, we will find in A.A.'s Eighth and Ninth Steps profound help in confronting ourselves as we are. Attending to the trivial invites examining "What kind of *person* am I to have done that?" The more trivial the "that," the greater the light shed upon "person."

The disproportion inherent in experiences of shame — the tendency of shame to be greater as its apparent occasion is smaller — also reveals something about the appropriateness of Alcoholics Anonymous as a therapy for shame. In a sense, shame is addictive. The disproportion in the shame reaction tends to magnify shame itself: we become ashamed at the very inappropriateness of our reaction, and therefore ashamed of shame itself. Shame becomes, in a way, insatiable: the more we feel it, the more we feel it — a vicious circle not unlike the squirrel cage that is alcoholism. Perhaps because of this parallel, it is this characteristic of shame — the apparent triviality of its occasion — that I found it most helpful to fasten on, as I progressed in sobriety, in trying to turn experiences of shame to constructive use. Let me try to explain why and perhaps also to show how.

Alcoholics Anonymous teaches us to locate the "root of our troubles" in the selfishness of "self-centeredness" — in *pride*. As drinking alcoholics, we think ourselves exceptional, special, *different*, and this tendency does not suddenly cease in early sobriety. This is one reason why we hear so often at A.A. meetings the advice: "Identify, Don't Compare." That is, concentrate on how you are *like* us, not on how you think you are different. Despite that frequently repeated warning, however, most of us go through a stage, in early recovery, in which our enthusiasm for A.A. and for the very newness of the

experience of honesty tempts us to judge and proclaim ourselves, as we review our personal history of alcoholism, *especially* "wicked."

I cannot claim to have completely escaped that trap in my own early sobriety, but something I heard in treatment helped me at least avoid becoming mired in it. A speaker told us that for *both* drinking and sober alcoholics: "The alcoholic's problem is not that he feels, 'I am a worm'; nor even that he feels, 'I am very special.' The alcoholic's main problem is that he feels, 'I am a very special worm.' "

That insight has helped me in many ways. At times, I'm sure you've noticed, even "good" A.A. meetings seem momentarily to be in danger of degenerating into "Can you top this?" competitions. When that begins to happen (and I must admit that at times I catch myself contributing to it) remembering "very special worm" helps to rescue me, and often the meeting. After all, our telling of stories at A.A. meetings is related to (although not the same as) the Fifth Step of the A.A. program. They are most alike, indeed, in providing therapy for precisely the "very special worm" snare:

"Admitted to God, to ourselves, and to another human being, the exact nature of our wrongs." Such confession is, of course, an ancient religious practice as well as a modern therapeutic technique. But Alcoholics Anonymous took it over directly from the Oxford Group within which A.A. was born, and the Group used the public confession of "sharing" specifically to minister to its adherents' shame rather than their guilt. As one of the Oxford Group books used by the early A.A. members says: "This sharing leads to the discovery that sins we thought were so bad are quite run-of-the-mill. The regard of one's sins as particularly awful is a vicious form of pride that is overcome by sharing."[6]

The A.A. practice of story-telling at meetings, like the more private Fifth Step , serves the same function: to drive home the

point that the alcoholic is very ordinary. I suspect this is why Bill Wilson, in writing about A.A.'s Fifth Step in *Twelve Steps and Twelve Traditions*, presented it as ending "the old pangs of anxious apartness" and beginning the alcoholic's "emergence from isolation."

Exposure

Because shame's stimulus is so often trivial, shame itself frequently catches us by surprise. This helps to make experiences of shame episodes of exposure. Experiences of shame throw a flooding and searching light on what and who we are, painfully uncovering unrecognized aspects of personality. Exposure to oneself lies at the heart of shame: we discover, in experiences of shame, the most sensitive, intimate, and vulnerable parts of our *self*.

Somerset Maugham, in his study *Of Human Bondage*, acutely penetrates the essence of shame as the exposure of one's own weakness. The story describes a boy, Philip, away from home for the first time, at school. Philip has a clubfoot, and his new classmates tease him, demanding to see his deformity. Although he wants their friendship, Philip refuses to show the other boys his deformed foot. One night, however, a group of the boys attack Philip in the dormitory, after he has gone to bed. The school bully twists his arm until Philip sticks his leg out of the bed, allowing them all to stare at his misshapen foot. After a moment of laughter, the boys run off. And Philip?

> Philip . . . got his teeth in the pillow so that his sobbing should be inaudible. He was not crying for the pain they had caused him, nor for the humiliation he had suffered when they looked at his foot, but with rage at himself because, unable to stand the torture, he had put out his foot of his own accord.[7]

Exposure of his deformity to others was less painful to Philip than the exposure to himself of his own weakness.

Alcoholism — in fact, any chemical dependency — often arises from and is almost always connected with the effort to conceal weakness, to prevent its exposure *to oneself*. The alcoholic or addict uses a chemical in order to *hide*, and especially to hide from self. The attempt at hiding reveals that the critical problem underlying such behavior is *shame*.

This is one reason why distinguishing between shame and guilt is so important. It is also a large reason why the more classic therapies, or the usual consolations of religion, provide little help to the alcoholic. During the years I was drinking, wanting to be absolved of guilt was *not* my major problem. If anything, I was pleading dimly but passionately within myself *to be able to feel guilty*. At some deep level I knew, even as an active alcoholic, that others' admonitions to "mend my ways" or even marshalling my own will to "grow up" didn't work. But I sought out such admonitions, at times, from therapists and clergy, and I at least went through the motions of such willing.

Yet, more deeply, I somehow realized, even as I did all this that I had to maintain my addictions. What I didn't realize, then, was that I had to in order to conceal my unendurable shame from myself. Of the other therapies I tried — or pretended to try — many, *couldn't* work, because I could not afford to allow any interference with my true problem of chemical dependency. Any such interference seemed to threaten my very being, and so I sought help only from those who I knew — or hoped — would not interfere with it.

Let me tell you — or remind you — of something that we all know now, as recovering alcoholics, but refused to face then, as active alcoholics: a major component of alcoholic addiction is the attempt to avoid or to deny *pain*. The *real* pain that we try primarily to deny, let me suggest, is the existential pain of

shame: the gnawing hollowness of the fearful feeling that in some essential way we are failures as human beings.

Denial and hiding

We thus again see the wisdom of the "treatment" provided by Alcoholics Anonymous, which aims and claims not to cure our alcoholism, but to care for us as alcoholics. Because it realizes that *shame* is the root of our alcoholism, A.A. sets out directly to touch that sore nerve, to enable us to confront our own shame. A.A. does this by allowing — and at times even by bringing about — the humiliation that we had sought so desperately to avoid by our use of chemicals. The process, which we will explore at depth in the next three chapters, is amazingly simple. It is precisely our falling short, our shame as alcoholics, that becomes the source of our new sober life in A.A. We come to see, in Alcoholics Anonymous, that our most meaningful strengths flow directly from our most shameful weakness.

It is fascinating to observe how Alcoholics Anonymous cuts through our last vestiges of prideful denial and taps our humiliation and shame. We see it most clearly with beginners although groups will apply the same treatment to oldtimers. Perhaps because I sought help from so many other places before Alcoholics Anonymous, I cherish an image that I think aptly sums up the essence of A.A.'s initial approach to our shame.

Any hurting person who seeks help brings to therapy a tiny, flickering flame of self-respect. Classic, guilt-oriented therapies strive to nourish that tiny glimmer, to enlarge self-respect. The initial response of Alcoholics Anonymous is different. Newcomers who display self-respect meet with caring confrontation: they are offered, for example, a carefully half-filled cup of coffee. Such confrontation of lingering denial invites hesitant newcomers to acknowledge the fact of their shakes and to realize that the coffee-server who recognizes the shakes accepts them. The

message is less "It's okay" than "It's tough, but I've been there too." More stubborn cases may, in time, be told: "Take the cotton out of your ears and put it in your mouth!" Any flicker of self-respect that reveals denial of the felt worthlessness of shame is gently quashed rather than nourished within A.A. Why? Because A.A. experience testifies that, until that denial is shattered, its own constructive therapy cannot be effective. The alcoholic must confront self-as-feared to find the reality of self-as-is.

Denial is the characteristic defense of alcoholics. Against denial, the shared honesty of mutual vulnerability openly acknowledged operates most effectively. Denial involves the *hiding* of felt inadequacy of being. Shame, as herein explained, relates so intimately to denial because it results not merely from a sense of failure, but from a sense of *essential* failure — failure *as a human being*, the failure of *existence*. This understanding captures, I believe, the insight of Dr. Harry Tiebout, who was Bill Wilson's own therapist and whose writings help so many of us understand both our alcoholism and our recovery. Tiebout's greatest contribution was his distinction between "compliance," which he saw as worse than useless because it obscured the obsessive-compulsive nature of alcoholism; and "surrender," which he presented as the key to the process of recovery. Tiebout's compliance may be understood as motivated by guilt: surrender, as enabled by the alcoholic's acceptance of shame.

Denial, Tiebout realized, could continue despite acknowledgment of guilt — despite, indeed, attempts to make amends for guilt. Guilt, he suggested, could even be a defense against confronting and accepting what is denied. For example, when an alcoholic accepts responsibility for what he or she did while drinking as preferable to admitting that the drinking itself was out of control, then guilt is a form of denial. That was a trick I often played on my unwary therapists, some of whom fell into the trap

of praising my "maturity" and "responsibility" and my "taking charge" of my own life. Ha! Real guilt fears punishment and tries to escape it. The person whose problem is shame, on the other hand, tends to seek and even to embrace punishment. Admitting "guilt," and paying for it, confirms the denial of what is most deeply feared and most profoundly painful — the sense of having failed as a human being. How sweet it was to be praised for my "honesty" at the very moment that I was being most dishonest, to be commended for my "courage" at the very moment that I was being most cowardly! *Sweet?!*

My alcoholic and chemical history was one long tale of ever-increasing denial and hiding. I hid from others and from myself. I denied not only my alcoholism and chemical dependency, but ever larger areas of my life and realities about myself. I tried to pull over myself that chemical veil, to deny reality by hiding behind alcohol and pills, until one day it seemed that there was nothing left to hide. Not "nothing else" — *nothing at all*.

At that hollow, empty moment, moved by the love of two A.A. members, a clergyman and a cop, I reached out for treatment and for Alcoholics Anonymous. Abandoning my denial and hiding and beginning to find my real self was not easy. I remember vividly an incident in treatment: a group session after we had somewhat begun to know each other and the principles of A.A. I forget exactly what I was talking about; but I do recall that I was trying so hard to be honest, yet sensing within myself and from the glances of the group that somehow my denial was still clinging to me, and I to it.

My words trailed off into silence. Finally, one of the group members, a young counselor-trainee, looked at me sadly and spoke gently in words of pained love: "If you — *all* of you — were ever on that TV show where they said, 'Would the *real you* please stand up!' . . . you wouldn't know what to do, which one of you should stand up, would you?"

The blinding accuracy of those words cut, but the love and concern and identification that I heard in them — and in the empathetic, understanding nods of the others in the group — began to heal. On occasion, as I progress in sobriety, I re-live that scene in my imagination. A few times, when I have felt the need for help with my continuing denials and fearful hidings, I have re-told the story at my A.A. discussion group. Each time, I have been healed further.

Recovering alcoholics know the treacheries of denial and hiding. And we learn, from the wisdom of A.A., to tap the trivial instances that expose our shame. That exposure, within A.A., allows and invites us to move beyond our alcoholic denials and hidings. Exploring how this happens and why it works is the task we turn to in the next chapters.

Part II:

Coping with Shame

Needing Others

Growth in sobriety may be understood as the continuing process by which we get beyond our hiding, transcend our denial, solve our shame. How do we achieve this? Alcoholics Anonymous provides a *model* and suggests a *method* of attaining continuing growth. The *model* is A.A.'s penetration of our denial that we are alcoholics. The *method* is A.A.'s inculcation of the reality that as limited — alcoholic — human beings, we need other people. Other people are not the problem in shame, but the solution. Denial and shame have to do with our limitations. We deny our need for alcohol and other people because admitting our need forces us to face our limitations. We hide our limitations because we are ashamed of them.

Early in my alcoholic career, I denied to myself as well as

to others that I was seeking comfort or excitement in alcohol because other *people* could not fill my insatiable needs. At parties, for example, "a few drinks" and a strategic location near the liquor supply became far more important to the "success" of the evening than any people I might meet. Alcohol more and more furnished a surer source of satisfaction than "all that silly party conversation." A bit further down the road of alcoholism I shifted more directly to denying any need for others: "Just let me alone — I can lick this thing by myself."

Alcoholics Anonymous worked — and works — for me because its fellowship and program continually break through these twin denials of my need for alcohol and my need for others. A.A. as a fellowship helped me discover and admit my need for others by being the one place — the *only* place by the time I got there — where I myself was needed, and *needed precisely and only as an alcoholic.* Realizing that enabled me to admit that I was an "alcoholic" and, therefore, to admit my insatiable need for alcohol. As a program, A.A. builds on my acceptance of myself as an alcoholic and an ever deepening awareness of my need for others. Without those others in A.A., I could never have admitted my own alcoholism. And I fairly soon came to realize that the "We" that begins the First of A.A.'s Twelve Steps stands also at the beginning of the other eleven.

Outsiders who study Alcoholics Anonymous usually recognize and often even fasten on our twin admissions of need — for alcohol and for other alcoholics. Many of the supposedly smart ones look down upon us because of these admissions: they try to explain away our recovery according to "labeling" or "deviant role" theories; or they interpret A.A. away as "the substituting of a social dependence for a drug dependence," or as "accepting the emotional immaturity of alcoholics and supplying a crutch for it." We know better, I think, and we do not need outside support — although there happens to be plenty of that, and also from

some pretty respectable "smart" people — to validate the joyous reality of a human life, humanly lived, to which our own lives and the stories of over a million sober members of Alcoholics Anonymous attest.

In dealing with shame, as I have tried to suggest, other people are not the problem, but the solution. The experience of Alcoholics Anonymous teaches us further that, for "others" to be shame's solution, they cannot be *merely* "others" — merely, that is, objects. Within A.A. we do not relate to each other "objectively." Objectivity is a quality that is valued in the medical — the curing — model. Think, for example, of the surgeon. Surgeons do not operate on their own family members, on persons with whom they have a *caring* relationship. Further, even the ordinary patient's body is so prepared and draped for surgery that his or her personhood and individuality are concealed insofar as possible. Everything about the ritual and procedures of the operating room is designed to enable surgeons to perform their skills upon a body rather than upon a person.

But Alcoholics Anonymous is not medicine nor surgery. In fact, one thing the early A.A. members found most objectionable about the Oxford Group was its use of the term "soul-surgery." That first generation of Alcoholics Anonymous sensed that wasn't how *they* worked, how A.A. worked. The uniqueness of Alcoholics Anonymous was that it did not claim to cure, but to *care*. In A.A., therefore, "others" are not *objects* who are "out there." "Identify, Don't Compare" mandates getting inside of and being with, as opposed precisely to standing off or viewing "objectively."

Accepting persons *as persons*, as fellow subjects rather than as mere objects, is the key to the A.A. model of *caring* rather than curing. This caring model pioneered by and lived out within Alcoholics Anonymous presents fully *human* relationships as characterized by two qualities: complementarity and mutuality.

to help other alcoholics: none of them wanted what Bill thought he had to give. But on Mothers' Day of 1935, when Bill found himself stuck in Akron, Ohio and became desperately afraid that he would drink again, he sought out Doctor Bob Smith for what Bob, as an alcoholic, *could give him*. Bill sought out Bob not to give, but to get: because of this, his attempts to give finally became effective. Doctor Bob listened and was touched, because Bill not only admitted his own need for him, but even *thanked* Bob for listening,and for thus helping him — Bill — to stay sober.

Perhaps an even clearer and more significant moment occurred at the bedside of the alcoholic who was to become "A.A. Number Three." Wilson and Smith told Bill D., when they called on him in the hospital, that talking with him was the only way *they* could stay sober. Bill D. believed them and *therefore* — as he tells us in his own story — he listened.

> All the other people that had talked to me wanted to help *me*, and my pride prevented me from listening to them, and caused only resentment on my part, but I felt as if I would be a real stinker if I did not listen to a couple of fellows for a short time, if that would cure *them*.[8]

Do you see the point — the first "secret" of A.A.? Somewhere in the world, at this very moment, two A.A. members are finishing up with an obviously "hopeless" Twelfth Step call. They have each told their stories to the bleary-eyed, swaying drunk who popped down "one or two more for courage" after calling the A.A. number, and they are wondering whether this sorry hunk of humanity, besotted with booze and self-pity, even heard anything they have said. Clearly, they can do nothing more today; but as they stand up to leave, one of the callers remembers what makes a "successful" Twelfth Step call and blurts out in honest gratitude: "You've got our phone numbers, and I hope you'll call when you're feeling better. I don't think

we've helped you much today, in the condition you're in, but I want to thank you for helping me. Seeing you like this, and telling you my story, helps me keep sober today. I know that I'm not going to take a drink today, and I thank you for giving me that gift and this opportunity."

And somehow, perhaps, *that* message gets through the alcoholic's self-pitying haze of self-hatred. That honest "thank you" somehow taps the desperation that motivated the call to A.A. It touches and soothes the absolute sense of "no good" that eats away at the alcoholic's last shred of self-respect. Whatever else is said as the Twelfth Steppers leave, the alcoholic knows that something has changed, something is now different. There is a place, there are people to whom the alcoholic has something of value to give.

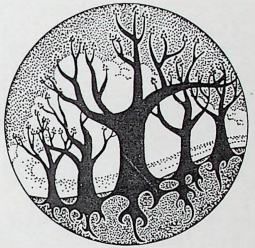
Every human being *needs* to make a difference. Alcoholics Anonymous recognizes and utilizes this reality, and thus its wisdom taps an unchanging truth of the human condition. To be human is to require "significance" — *place* in another person's world.

> It seems to be a universal human desire to wish to occupy a place in the world of at least one other person. Perhaps the greatest solace in religion is the sense that one lives in the Presence of an Other.[9]
>
> . . . .
>
> We ourselves want to be needed. We do not only have needs, we are also strongly motivated by *neededness*. . . .We are restless when we are not needed because we feel "unfinished," "incomplete," and we can only get completed in and through these relationships. We are motivated to search not only for what we lack and need but also for that for which we are needed, what is wanted from us.[10]

We introduced, in the preceding chapter, the terms "mutuality" and "complementarity." Mutuality implies having signifi-

cance, making a difference, by *both* giving and getting. Complementarity means that one both gets *by* giving and *by* getting. Alcoholics Anonymous not only teaches these truths — it enables even the most "hopeless" drunk to live them out, and by living them out to attain the honorable condition of alcoholic. When we say at A.A. meetings, "I am an alcoholic," we proclaim not only that we need, but that even from the depths of our need, we have something to *give*.

We learn, as recovering alcoholics, that we need. By accepting our need, we confront our shame. But one of our deepest needs, we discover, contains shame's solution — *if* there are others like us. The need to be needed is the solution for our shame. The need to be needed gnaws sharply. If shame is to be resolved, we need to be needed *for our very need*. To find this need met is to put shame itself to shame.



Honesty with Self and with Others

The second mutuality that we learn and live within Alcoholics Anonymous involves honesty. A.A. experience vividly teaches that there is an essential connection of mutuality between honesty with self and honesty with others. Most alcoholics who reach Alcoholics Anonymous already know quite a bit about the necessary mutuality between honesty with self and with others. Our drinking experience before reaching A.A. was, after all, one long, downhill story illustrating the inevitable mutuality between *dishonesty* with self and with others.

Remember how successful we were for a time? After convincing ourselves that we didn't have a drinking problem, how we managed to convince others? And after convincing a few compliant friends, how we then used their "evidence" to reconvince ourselves? I recall an interesting first few months when I returned from treatment, having finally found A.A. Back

home, I began telling a few close friends that I was an alcoholic and had joined Alcoholics Anonymous. Guess what? You know, I'm sure, how a lot of people are about A.A. anyway. Well, several of my erstwhile friends tried hard to convince me that I wasn't "really" an alcoholic (can you hear their tone of voice?) — and they gave back to me all the arguments and "proofs" that I had fed them over the years! We really need our sponsors — someone with whom we have established a relationship of honesty — especially during such beginnings.

"Those who deceive themselves are obliged to deceive others. It is impossible for me to maintain a false picture of myself unless I falsify your picture of yourself and me."[11] Yes — and our alcoholic experience also teaches us the complementary truth: "Those who deceive others are obliged to deceive themselves. It is impossible for me to project a false picture of myself unless I falsify my own picture of me and of you." The quotation below portrays what I have come to understand about this aspect of my alcoholism much better than I could:

> As a child grows gradually aware of the absolute separateness of his being from all others in the world he discovers that this condition offers both pleasure and terror. . . . To the extent that he must — or believes that he must — toy with his own presentation of himself to others to earn the attention and approval he craves. . . he will experience a queer, unnamable apprehension. . . This uneasy state is both painful and corrupting.
>
> It is commonly believed that this pain and corruption are consequences of his low self-esteem and fear of others' indifference and rejection, that these cause him to project himself falsely. It seems more likely that once this habit begins to harden, the crucial source of pain is his corruption. In his constant inability or unwillingness to tell the truth about who he is, he knows himself in his heart to be faking.
>
> Not merely is he ashamed of having and harboring a secret, unlovely, illegitimate self. The spiritual burden of not appearing as the person he "is," or not "being" the person he appears to be — the extended and deliberate confusion of seeming and being — is by and large intolerable if held in direct view. If the integrity he craves is to be denied him, at least he will have its illusion. If he cannot publicize his private self. . . then he will command his private self to conform to the public one. This beguiles to a *loss* of truth; not only "telling" it, but *knowing* it.
>
> There are some things it is impossible both to do and at the same time to impersonate oneself doing. Speaking truthfully is one of them.[12]

As often now, in sobriety, as I have meditated on that description, a new tingle of recognition goes through me each time I re-read it. Those words touch deeply and sharply one precise shame of my alcoholism: its vicious circle of dishonesty. I have learned in A.A., from A.A., that it is necesary to avoid self-deception if one is to be honest with others, and that at the same time one must be honest with others if one is to avoid self-deception. One great gift that I have received from Alcoholics Anonymous is the vision that this circle of mutuality need not be "vicious." If there is a mutuality between dishonesty with self and with others, there is also a mutuality between *honesty* with self and with others. The key to breaking the vicious circle of alcoholic dishonesty is the honest admission, "I am an alcoholic."

Our honesty in sobriety, of course, reaches far beyond that first admission. Our alcoholic dishonesty when drinking, after all, extended far beyond our denial of alcoholism. One reason why Alcoholics Anonymous works so effectively is that its meetings furnish an ideal format for reaffirming and extending that first honesty with self and with others. The honesty of each, at an A.A. meeting, enables the honesty of all. Among you, I cannot be dishonest, with you or with myself. You do not let me, for you need my honesty as I need yours. And our honesty, established in this way, grows, touching ever wider areas of each

of our lives. A much-maligned modern philosopher has called the "bad faith" of self-deception the ultimate sin. Living the A.A. program, within the A.A. fellowship, delivers us from its evil.

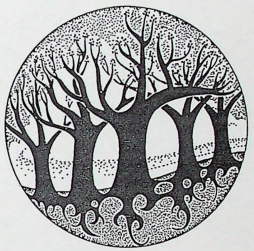
Dishonesty becomes a habit, an addiction as tenacious and as treacherous as alcoholism itself. If I am to find the real me, I need your honesty. I need your honesty in order to find my own. And one reason I love going to A.A. meetings is that I sense that you have the same need. Because you need my honesty as I need yours, we all give by getting and get by giving.

I'd like to conclude this chapter by sharing with you another honest secret about the real me. Because children are so honest and simple, I love to read children's books. In one of them, Margery Williams's *The Velveteen Rabbit*, I came across something about being "real" that I think pretty well sums up how A.A. works for me as far as being real is concerned.

Early in the story, the young Velveteen Rabbit asks another toy, a wise, old Skin Horse, "What is REAL? . . . Does it hurt?"

> "Sometimes," said the Skin Horse, for he was always truthful. "When you are Real you don't mind being hurt."
>
> "Does it happen all at once, like being wound up," the Velveteen Rabbit asked, "or bit by bit?"
>
> "It doesn't happen all at once," said the Skin Horse. "You become. It takes a long time. That's why it doesn't often happen to people who break easily, or have sharp edges, or who have to be carefully kept. Generally, by the time you are Real, most of your hair has been loved off, and your eyes drop out and you get loose in the joints and very shabby. But these things don't matter at all, because once you are Real you can't be ugly, except to people who don't understand."[13]

I love Alcoholics Anonymous because I find in A.A. people who *do* understand. And A.A.'s greatest gift to me, after sobriety, I like to think and to hope, has been to help me become not only REAL, but someone who also understands.



Dependence and Independence

Both mutualities already examined — those of making a difference and of honesty with self and with others — flow into the third mutuality taught and enabled by Alcoholics Anonymous: that between personal dependence and personal independence.

As with the earlier mutualities, A.A.'s insight into the necessary connection between dependence and independence derives from its intuition that the reality of essential limitation is the first truth of the human condition. It is because the human is somehow the juncture of the infinite with the limited — because to be human is to be both angel and beast, "a god who shits"[14] — that human dependence and human independence must be mutually related, not only *between* people, but *within* each person. Mutuality means that each enables and fulfills the other.

To speak of a mutuality between dependence and independence, then, is to point out not only that *both* are necessary within human experience, but also that *each* becomes fully human and humanizing only by connection with the other.

Remember the image and its message, explored earlier, "Humbly on our knees"? A.A.'s mandate and caution to the alcoholic are one and the same: "You can do something, but not everything." To be human is to be in a *middle* position, and therefore to combine rather than to choose between dependence and independence. When we were drinking, we alternated between the defiant claim, "I can do it alone," and the desperate plea, "Please do it for me." Sobriety means putting aside both of those cries and accepting not only that we ourselves must do *something*, but that we need others in order to be able to do even that "something." The sober alcoholic learns in Alcoholics Anonymous both to acknowledge dependence and to exercise responsible independence. When, for whatever reason, the thought of chemical relief crosses my mind, it is *I* who pick up the *telephone* instead of the bottle — that's responsible independence. But it is the *telephone* that I pick up — and that acknowledges my dependence, my need for others.

Too many other therapies — the therapies at least that I tried before finding A.A. — look down upon the A.A. way because they prefer to interpret personal dependence and personal independence as contradictory rather than as mutually fulfilling. Their goal of independence for the alcoholic is not unrelated to their ideal of "objectivity," which leads them to ignore mutuality, and to their hope of *curing*, which stands in the way of their *caring*. Yet, as we have seen, as alcoholics we gain the freedom to not-drink only by acknowledging that our problem is not *dependence* on alcohol, but dependence on *alcohol*.

The Alcoholics Anonymous model of mutuality and caring works because it rescues alcoholics from the dire need and the

doomed effort to deny all dependence. A.A. members, because they accept their essential limitation as humans, come to understand that dependence demeans and dehumanizes only if that which is depended upon is less than human. It seems to be a law of human growth that we become what we depend upon. Our choice as alcoholic human beings is not between dependence and independence, but whether we shall be dependent on a less than human substance such as booze, or on a more th individual reality such as our "Higher Power" however unde. stood. And most of us, I think, find at least the best evidence o. our "Higher Power" in others — especially in other alcoholics.

In the A.A. understanding, the truly mature person is characterized not by "independence," but rather by what some psychiatrists have termed "ontological security." For the person so secured, "dependence or independence do not become conflicting issues, rather they are complementary."[15] Such a person finds relatedness with others potentially gratifying and fulfilling.

The "ontologically insecure person" described by these therapists, on the other hand, closely resembles the active alcoholic. Having failed to come to terms with the complementarity of dependence and independence, such a person becomes preoccupied with *preserving* rather than fulfilling the self. Obsessed with the task of preserving, the ontologically insecure person reaches out to others in *self*-seeking dependency, out of the same needs that drive the alcoholic or addict to seek chemical relief.

Let me try to illustrate from my own story, which contained many attempts to treat my alcoholism through the more classic therapies. Those efforts proved unfruitful until I discovered *their* fulfillment in Alcoholics Anonymous. Several therapists suggested to me, as Dr. Harry Tiebout had pointed out to Bill Wilson, that the alcoholic seems to be fixated as a perpetual infant. The

alcoholic is like the newborn infant whose cries are meant to enforce the demands of grandiose omnipotence — "His Majesty the Baby," in Tiebout's Freudian phrase.

Periodically for the alcoholic, however, as for the baby, the pinchings of reality push this sense of grandiose omnipotence to its opposite extreme. The self-pity of the hurting alcoholic echoes the implicit complaint of early childhood after the individual becomes aware of his or her relative powerlessness in a world of mature adults. From the demanding claim, "I am everything," the disillusioned alcoholic — like the helpless child — moves to the lament, "I am nothing." This understanding reflects, I think, the "very special worm" insight that we explored earlier.

Before I found A.A., my therapists all tried to convince me that maturity meant accepting the middle between "I am everything" and "I am nothing." Maturity, that is, meant embracing the realization that the proper affirmation for human beings runs, "I am something." I tried to accept that, to live it — oh how I tried! The trouble was that when things went well, I tended to lean on the first syllable — to think and to act out the sense "*I* am something." And when things were not going well, when reality pinched, I was inclined to add a word that signaled my alcoholic exceptionalism: "I am something *else*" expressed a demand that implicitly denied essential limitation. In both cases, it seemed logical and even necessary to turn again to alcohol — either to sustain the self-centered inflation of "*I*" or to enforce the self-centered exclusiveness of "something *else*."

Alcoholics Anonymous, when I finally found it, suggested a further growth, a different maturity. Because it sees "selfishness — self-centeredness" as "the root of our troubles," because also of its sensitivity to the alcoholic as human being rather than as object, A.A. offered me an alternative to "being something." In its fellowship, I learned, I was to become someone. "I am someone" reflects more accurately human reality as essentially

limited. "Someone" invites a double accent, thus removing all emphasis from the "I."

Because I learned in A.A. to accept being *some*-one, I no longer needed to try to be all; nor did I need to complain of being nothing. Both infantile claims of my alcoholic personality were closed off. Because I embraced being "some-*one*," I became able to fulfill and to be fulfilled by others, rather than threatening or being threatened by *their* individuality. I thus began to live the joyous pluralism of complementarity that has been pointed out as the essential dynamic of Alcoholics Anonymous: "the shared honesty of mutual vulnerability openly acknowledged."

The concept of "*some-one*-ness" really helps me to see the inherent mutuality of being human as a sober alcoholic in Alcoholics Anonymous. I cannot be *either* wholly dependent *or* wholly independent. To be human is to be *both* independent and dependent, and because both, neither totally. I can achieve true independence only by acknowledging real dependence. Similarly, I am able to be dependent in a truly *human* way only if I also exercise real independence. My independence is enabled and enriched by my dependence.

Once I heard an A.A. speaker suggest that in a sense we "charge batteries" by periodically acknowledging dependence. It is that acknowledgment that allows our independent operation. And, the speaker went on to point out, the other side of the image is just as true. We can't be only dependent and never exercise independence, for that would be like over-charging a battery that is never used: it would destroy both the dependent self and the charging source. The trouble with this image is that it implies some sort of "either-or" sequence. In human reality, among us as members of Alcoholics Anonymous, dependence and independence do not so much alternate as reciprocate. Our needs for dependence and independence are not met one after

each other, but at the same time, in such a way that they mutually reinforce each other even as they mutually satisfy each other.

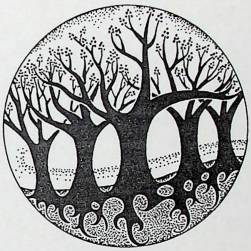
Note how well A.A. teaches and enables this, not only by its suggestion that we have some "Higher Power," but even in the way that its program and meetings work. The very First Step of the Alcoholics Anonymous program already contains the whole point here and establishes the foundation for its deeper understanding. Only by admitting that we are powerless over — and therefore dependent upon — alcohol, do we achieve the independence of freedom from addiction to alcohol.

The mutuality between personal dependence and personal independence, which we have explored in this chapter, also aids our deeper understanding of the A.A. emphasis on *limited* control and *limited* dependence. It is similar to the difference between "I cannot drink" and "I *can* not-drink"; and the distinction between "*dependence* on alcohol" or "dependence on *alcohol*." If those suggestions rang true then, I hope that you now share my vision of why they are true. Each is true because the other is true. As I learn so often in A.A., in so many ways, I am real because I am limited, just as I am limited because I am real.

All that may sound strange — even weird. Yet, if you have been where I have been, and of course you have, I think you understand. Remember? The agonizing over whether to drink at all in a situation in which we fear that there might not be "enough"? For us, when we were actively drinking, was there *ever* "enough"? The double falsity, then, of saying "No," or of "protecting our supply" when, for example, unexpected guests dropped in over a holiday when the liquor stores were closed? Were we ever "real" when, denying limitation, we thus played false? Or how about the games of hiding from ourselves? One of my favorites was to "cut down" by buying fifths instead of quarts;

only I made sure that the fifths — do notice the plural — were of one hundred proof instead of eighty proof.

Today, sober, I no longer have to play such games. Accepting that I am an alcoholic, accepting that I am essentially limited, I have found the reality of my dependence and of my need. I have also found — or at least am in the process of finding — the reality of myself: and *that* is *real* independence."



Conclusion

I am an alcoholic. Accepting that, I can be myself. And strange as that may seem to some, impossible as that was when I was actively drinking, I like it. In fact, I love it so much that I wouldn't exchange it for anything else, and because it is the most precious thing I have, it is what I have tried to share with you in these pages. I hope that by your reading them we have both gained by giving, given by gaining. I know that I have; so — thank you. I would like to share with you in conclusion, and out of gratitude, something that I came across recently. Its author called it "an alcoholic's meditation on honesty, pain, and shame":

> Honesty involves exposure: the exposure of self-as-feared that leads to the discovery of self-as-is. Both of these selves are essentially vulnerable: to be is to be able to hurt and to be hurt. But something tells us that we should not

hurt: that we should neither hurt others nor hurt within ourselves. Yet we do — both hurt and hurt, both cause and feel pain.

When we cause pain, we experience guilt; when we feel pain, we suffer shame. The pain, the hurt, the guilt of the first is overt: it exists outside of us, "objectively." The pain, the hurt, the shame of the second is hidden: it gnaws within, it is "subjective." Neither can be healed without confronting the other. A bridge is needed — a connection between the hurt that we cause and the hurt that we are.

That bridge cannot be built alone. The honesty that is its foundation must be shared. A bridge cannot have only one end. Without sharing, there can be no bridge. But a bridge needs a span as well as foundations. This bridge's span is vulnerability — the capacity to be wounded, the ability to know hurt. "I need" because "I hurt" — if deepest need is honest. What I need is another's hurt, another's need. Such a need on my part would be "sick" — *if* the other had not the same need of me, of my hurt and my need. Because we share hurt, we can share healing. Because we know need, we can heal each other.

Our mutual healing will be not the healing of curing, but the healing of caring. To heal is to make whole. Curing makes whole from the outside: it is good healing, but it cannot touch my deepest need, my deepest hurt — my shame, the dread of myself that I harbor within. Caring makes whole from within: it reconciles me to myself-as-I-am — not-God, beast-angel, *human*. Caring enables me to touch the joy of living that is the other side of my shame, of my not-God-ness, of my humanity.

But I can care, can become whole, only if you care enough — need enough — to share your shame with me.

Could the same be true for you? It has been for me. Thank you for your time and your sobriety, for the hurt and the need that led you to read these pages. It is my prayer that my need and my hurt, which moved me to write these pages, may help to heal yours and you.

The Golden book of RESENTMENTS

THE GOLDEN BOOK OF RESENTMENTS

By
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SOBRIETY AND BEYOND

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RESENTMENTS

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"Whom the gods would destroy....."

In analyzing the various principles of Alcoholics Anonymous we now come to one which has come up for more discussion, and which is at the bottom of more difficulties than any of all the ones listed. This principle is:

"THE DANGER OF RESENTMENT—SELF PITY"

In the alcoholic, "frustration begot resentment, resentment begot self-pity, self-pity begot drinking, and drinking begot frustration, and frustration begot resentment, and resentment begot self-pity," and on and on and on—in an unending cycle, until faced with the three-pronged choice: sobriety or insanity or death. And then we chose sobriety in A.A. And we learned the principle that: *If the alcoholic repeated any PART of the cycle, the ENTIRE cycle would repeat ITSELF, "in toto."*

We learned through the above principle that to the alcoholic, *resentment and self-pity* would always remain his number one twin-enemy—*no matter how long sober.* And this means that, *if he permits himself to indulge in resentment or self-pity too frequently or for too prolonged periods of time, he will automatically set off the compulsion to drink. In short: AN ALCOHOLIC CANNOT TOLERATE RESENTMENT.*[1]

If he does, there automatically will begin the old pattern: "stinking-thinking; drinking-thinking; *drinking.*" And so also will it be with any part of the cycle above: If the alcoholic takes a drink, he will automatically and ultimately become full of resentments, etc. etc. We do not know *why* this happens, but *we do know from long, long experience that it does happen.*

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[1] In the writer's opinion self-pity is nothing more than resentment "turned inside out." Self-pity is the coward's type of resentment, and when such a person finds himself frustrated in vindicating his resentment, he turns "inside to himself" and becomes full of self-pity. So from this point on we shall only use the term "resentment" and in it include also "self-pity."

In fact the experience of the race, although somehow little is ever written or said about it, is that *at the bottom of most troubles in life,* including our spiritual life, *is resentment.* So important is this truth that *he who controls resentment* (and by this term we include any of the thousands of degrees of resentment from a mere "dislike" to a positive and malicious "hatred") *controls life here and hereafter.* Ninety-eight percent of all "troubles" in the lives of all people stem in some way, directly or indirectly, from resentments. And, in alcoholics—it is *without exception* the prelude to the bottle.

Now if this be true, then let us try to answer three very pertinent questions: What is resentment? Where does resentment come from? And what are we going to do about resentment?

The answers to all three of these questions are contained in the analysis of the term itself. "Resentment" comes from the Latin words "re" and "sentire." "Sentire" means "to feel" and "re" means "again." Therefore a resentment is born when one "re-feels" any injury to pride, and any "hurt" to one's ego. And so, when anything happens or exists that injures our pride, we are "hurt," "irritated," "angry" but not yet resentful. This injury grows into a resentment only because we "re-feel" it; we "nurse" it; we "mull over" it; we "dig around" it;—in short we "*cultivate*" it. We are injured, and we "infect" the wound because we "re-sentire": we "re-*feel*" it. And once infected, once the resentment has taken hold, then only a "positive antibiotic" will cure it or eliminate the poison. And in the area of hatred, toward which all resentment tends, there is only one antibiotic: that is *love.*

From this short analysis *three very important truths become apparent.*

1. *We get resentments from pride. We will always have this tendency, for pride will be with us until we are dead. But we can minimize this tendency and eliminate many an occasion by the PRACTICE of humility*—the opposite of pride.

Many people in this world wrongly think that they can "eliminate" various of their passions, eg. pride. Or as the story goes, a certain teacher of the spiritual life was teaching her proteges to "slay" one passion a year! This can't be done! We have seven basic passions, seven basic "drives to action," seven basic "human tendencies." It is "the law of the flesh fighting against the law of the spirit" mentioned by Saint Paul. But they *cannot be eliminated.* They are necessary for life, for action. They are *good* in themselves, but *tend* to get out of control. It is our job to *CONTROL them.* Closing our eyes to them is what psychiatry calls "repression" and is responsible for many neuroses. Let's take an example or two.

We all have the passion of lust: sex. To deny we have such drive or desire is "repression"—it is not healthy, and leads to neurotic behavior. *But* that does not mean we should therefore *indulge in sex. Sex indulgence never cured a neurosis.* But it does mean that we must *admit consciously that we have the sex drive,* and then *either* 1) use it according to reason in lawful marriage as indicated by our Maker *or* 2) *abstain wilfully* in the single state. These two are *"control"*—by 1) reasonable use or by 2) total abstinence. *Both are healthy practices,* for "abstinence" is *not* "repression."

Likewise we all tend to "get angry." (They say there are people in this world who *never* get angry or irritated. But then they also say there are people in this world who are too *dumb* to commit sin! But *we* ain't in that class, Bud!) That is a *good* tendency. It gives "drive" and "push" and "initiative" and all those things that go for successful living. *But* when it is *indulged in as a door to frustration, and vindication, and self-pity,* then it has gone "against reason" and also leads to neurosis—and in the alcoholic to *resentment and drinking.*

So we never even try to *rid* ourselves of these "tendencies." They will be with us until we are dead. *But* we can gradually *control and direct them* by *the practice of the opposite virtue.*

We *can by practice of the opposite* virtue achieve at least a modicum of control, minimize or cut down the number of occasions, and in the matter of pride, and "injured pride," which is the seed of resentment, we *can go far in cutting down the number of times and the severity of these "injuries" IF we DAY IN AND DAY OUT practice* the opposite virtue of humility. Let's not forget: *The greater a guy or gal I think I am, the less it is going to take for someone to dispute that idea!*

Therefore as a practical corollary to the above truth, we learn that *we cut down the number of chances of BECOMING resentful in direct ratio to how much true humility we acquire.*

2. *Resentments take hold and grow within us by "re-feeling" the injuries.* Therefore *they cannot remain or grow if we "let go" of them and refuse to think about them, refuse to mull over them, refuse to "re-feel" the irritation.*

Most irritations would evaporate quickly if on every occasion of being "angered" or "hurt" all parties involved would immediately *dismiss the incident from their minds.* But how often is it not the opposite? Instead of dismissing the injury at once, we hold on—we think it over—we "re-feel" it . . . over and over again. Then in twenty-four hours what was only a "scratch" has become a deep, dark, dangerous *resentment.* "What was that he said?" "Why, he meant...." "The so-and-so!" "I'll get even!" And—then "resentment begot....!" Remember?

What to do? *Let it go!* He said thus-and-thus. So what? Refuse to "re-feel"!

You know sumpin'? If someone calls us a "so-and-so," we either are or we aren't! If we are, that's that! If we aren't, then why become one by "getting 'mad' about it"!

3. *We eliminate those resentments already contracted NOT by wishing them away, but only by the practice of positive ACTIONS of love.*

We must *do* good to those whom we resent. We must speak *well* of those whom we resent. We must practice some positive *action* for love of them,—*and love is the willingness to do FOR.* Otherwise we will continue to resent, we will continue to dislike,[1] we will continue to hate—no matter how long or how deeply we might *wish* we didn't resent or dislike or hate.

And here again, the more consistent our *habit* of love is in our daily lives, the less chance for resentments to take hold; and also the more easily and quickly will they disappear when they do, on occasion, crop up.

In A.A. we find, especially in the beginning of our sobriety, that we are not very adept at the practice of humility and love. We have lived for so long with our drinking pattern that we have picked up pathological habits of pride and hatred and resentment. We were "loaded" with them. And now we find that we can use a few extra "natural" helps to sorta "protect" our touchy, alcohol-tenderized natures until we are more able to pursue a stable course along the path of virtue, particularly until we are more able to "control" our hurts more consistently. And so we picked up a few more than wise little sayings which if ingrained into our consciousness will serve as a suit of armor against "the slings and arrows of outrageous fortune."

The first of these "gimmicks" which we throw out for your perusal is:

EXPECT CRITICISM.

No matter who we may be, no matter how important or competent we may be, no matter how good either we or our motives

[1] There is a form of emotional "dislike" which is not from injured pride, but simply a reaction of nature's law of attraction and repulsion. It is like the positive and negative poles in the inanimate world. So certain people we like; but a certain few we will not "like," no matter what we do. What to do? Just don't try to "like them"—love them!

are, *if we do anything in life we will be criticised. But* any criticism is in no way a measure of the value, sincerity or morality of our actions. Now, if we meet each day in life *expecting criticism*, then, when it comes (and it *will!*) we will not be surprised, nor hurt, because we were *looking* for it—and we can even reach a state of mind wherein we so look for these criticisms that rather than upsetting us or irritating us *we enjoy them.*

The writer learned this first "gimmick" in the early days of his speaking and writing. He had the privilege of getting it first from Bill W., our founder. And, altho' for some time criticisms here or there did "irritate," he now so looks for them in every area that he enjoys them, like the funny papers on Sunday morning! He would almost feel "lost" without criticisms levelled at him.

"Gimmick" number two: *THERE IS IN EVERY GROUP OF HUMAN ENDEAVOR AT LEAST ONE WHO IS AGAINST EVERYTHING AND EVERYBODY. GOD PUTS THEM THERE —TO GIVE ALL OF THE REST OF THE GROUP A CHANCE TO PRACTICE TOLERANCE, AND PATIENCE, AND KINDNESS, AND UNDERSTANDING, AND LOVE.*

With this knowledge, it will be a pushover to tolerate and overlook all the diatribes of that "guy" or "gal" in your group who is *always* "agin" everything and who never lets anyone's work go by unchallenged, and who, in short, just doesn't seem to like anybody (including himself). They are to be pitied, not blamed. They are "psychopathic." But they are filling their "niche" in life which demands *all* parts to make the machine of life go on: yes, even the "nuts," and the bolts---and the ubiquitous "crank"!

One such fellow died. At his wake there was overheard the following remark: "Poor John (his name was John Doe) he won't like God."

The next "gimmick" to help protect that "tender" ego of ours is:

LET THE OTHER FELLOW GET MAD.

We are in A.A. (at least we presume most of us are) primarily to stay sober and secondarily to achieve and maintain happiness. Both sobriety and happiness are dependent one on the other. We can't be happy unless we stay sober; we won't stay sober unless we are happy. *Therefore* when someone "irritates" us, or criticises us or talks about us, *let the other fellow get mad.* He is unhappy. All people who criticise or gossip or slander are basically very unhappy people. We, on the other hand, want to be happy. So let's stay happy. Let them get upset or talk or what have you. We simply ignore it. We stay happy. We avoid resentment.

Some years ago when the writer arrived to speak at a large A.A. Conference, someone came "a-running" with the report that "someone was talking *awful* about us" and the "reporter" thought *we* should do something about it. We replied:

"*We* do something about it? Why should we? We're *happy*, and we are going to stay that way. He's unhappy. *Let him get mad.*" (Which he *did*!)

Another "gimmick":

WORDS CAN NEVER HURT NOR CHANGE US IF WE DON'T LET THEM. AND WE WON'T LET THEM IF WE ARE MORE CONCERNED ABOUT WHAT AND HOW WE ARE DOING INSTEAD OF WHAT PEOPLE ARE SAYING — FOR GOD ALONE CAN APPROVE OR DISAPPROVE, ABSOLVE OR CONDEMN.

What was that saying we heard in our early school days? "Sticks and stones may break our bones but words can never hurt us." Someone has criticised? Okay, what is that to us? *Let them criticise*, we will simply pursue our way of living happily and soberly and completely oblivious of any verbal ammunition that may be hurled our way. *Words* aimed our way will remain a mere "mirage" provided we neither run towards nor from their vocalizer.

"Gimmick" number five:

KNOW THYSELF.

An honest inventory of our own shortcomings will go far in eliminating that tendency to "take up" everything that is said about us or to "strike back" at critics. For if we are honest, we are pretty sure to accept *all* things in life more passively and readily. Like the story goes which tells of a fellow in tatters and rags, sitting on the curbstone, a "leetle" bit drunk, who was heard to mutter in a flash of honesty, as a very successful and wealthy gentleman passed in his limousine, *"There but for me go I."* We think he's got something there!

We will content ourselves with one more "gimmick," and one that will go far in encouraging anyone to keep on doing things *no matter who says what,* for:

IF WE GET A KICK IN THE PANTS IT CAN MEAN ONLY ONE THING—WE ARE STILL IN FRONT!

Someone said: "Criticism is the unconscious tribute mediocrity and failure pay to success." This explains our "gimmick." There is another way of putting it: "Every knock is a boost." (A school boy misquoted the above to read: "Every knock is a boast." He wasn't far wrong at that!). Get angry? How silly. Rather take a bow!

And now we shall give you a bag to keep all your "anti-resentment gimmicks" in. It consists of a bag and string to tie them all together. It belongs to each. Maybe we could call it a "gimmick-chorus." But anyway here it is, stolen from "Easy Does It":

HOW IMPORTANT CAN IT BE?

And if you want to see what we mean, just quietly sit down and think over all the irritations and resentments that have taken hold of you for the past month or so? *Most of them were over something that actually disappears when exposed to the importance of the over-all picture of living happily and soberly and justly—day in and day out.*

So in *all of our affairs* we *practice*: 1) *humility* in order to *avoid* irritations; 2) *refusing* to *"re-feel" any irritation to avoid*

resentment; and 3) *love—ACTIONS of love to eliminate resentments.*

1) *IN OUR HOME LIFE.*

Humility would tell us that we are *not* the most important guy or gal in our home relationship. Wisdom would tell us that being alcoholic we simply *cannot tolerate resentment.* Therefore we positively will *refuse to "re-feel"* any hurt apparent or real, from the other members of the family. And love *demands* practice—*actions of love,* day in and day out.

The attitude of humility will avoid many "hurts" or "irritations" from others in the family. The smaller our "ego" the less chance there is for it being "hit"—therefore the fewer upsets, irritations, etc. But being human, and since it is impossible to "eliminate" the ego, there will be irritations, and fusses, and hurt feelings. The family who is free from these just doesn't exist! It is part and parcel of life *but* we do not *have to nurse these hurts.*

To eliminate those resentments already picked up? *We simply refuse to "re-feel"* any hurt, or irritation, or slight, or whatever may be directed towards us—actually or apparently. And a conscientious regular inventory of our own selves will help immensely toward accomplishing this ability to "overlook" whatever is said or done to or about us. Then, no "re-sentire"... no "re-feel"—*no resentment!*

To eliminate those resentments already picked up? *We simply must practice love!* There just "ain't" no other way. And love means *doing FOR* the other—*love does not mean "making love."* This latter, this indulgence in passionate loving, in sex *is the reward of love and an expression of love, only if indulged in to please or increase the happiness of, or to satisfy the other in marriage.* Sex pleasure, sex satisfaction is the *human, fleshly* part of love placed there by the Creator to bind *"two in one flesh."* But when this is indulged in a selfish way—because *WE want it,* it will ever so gradually sap the vitality of both attraction and love. But if

indulged in because the *other wants it*, it will as the icing on the cake, ever so gradually make one's love more and more attractive and beautiful.

But like the cake itself which provides that on which the icing is able to exist so attractively, *you "gotta"* have cake or the icing will fall to pieces and have nothing on which to exist, so with love: unless there is "cake," unless there is *giving, doing FOR—day in and day out*—there just won't be any icing because there is nothing upon which to have it. And this "cake" of love consists in *actions done for the other for no other reason than to please them or simply because you love them.* They who practice this *giving* regularly will never be troubled with many resentments—neither with those that are already there, nor with those which might try to creep in. Okay, lad or lassy, *just how long has it been since you actually did something for your husband or wife, or children JUST BECAUSE YOU LOVED THEM?* Well, then, what do you expect ? ? ?

Let's always remember, relative to *resentments* in the home: Passion without actions of love, *will, whether one likes it or not, gradually dissipate BOTH LOVE AND PASSION; but ACTIONS OF LOVE faithfully practiced, day in and day out, will continually replenish and cultivate and perfect, as far as possible in this vale of tears, BOTH PASSION AND LOVE.* Try it!

2) *IN OUR SOCIAL LIFE.*

Here again the attitude of humility will tell us that we are not the most important, or even a "little important" person among our acquaintances—and no matter who we are *we must expect criticism*, and use all the "gimmicks" we can to avoid irritations. So for our social intermingling with our fellow man, we will find a "special gimmick" which should help us very much to avoid those "hurts," etc. which seem to constantly try to upset our sensitive natures. This "gimmick" is: *always do the best we can never EXPECTING praise or gratitude.* Why? Well, humans being what they are, you just won't get much of either—so no disappointment,

no "upset." Remember, what the Lord once said, "I will repay"? So, let's *not expect much from people.* (They are all too busy expecting from you!) A good conscience and the approval of God will be the never-failing result of the habit of looking to God instead of to people. Even though "the best of men likes a wee bit of praise now and again."

There was one individual who claimed he had reached this habitual practice of never looking for praise—claiming that all such "ran off him like water off a duck's back." One time after a rather successful and well-accomplished action, a little old lady came to heap praises upon him.

"Madam," he said, "all that runs off just like water off a duck's back."

"Yes, I know," replied the lady, "but oh how the duck likes it!"

To refuse to *LOOK* for it is possible; to refuse to *"LIKE"* it is impossible. We are human.

Yet how many resentments begin with those so-called "slights" in not being praised or being thanked. How often we hear: "And to think they *didn't even thank me!*"

"Don't expect from people."

And if by chance we *have* already picked up resentments, against certain of our fellow men, then there is only one way to get rid of them: *Do something good for them, or to them or* in short *practice* love—*actions* of love.

3) *IN OUR BUSINESS.*

No man in the business world ever had much business acumen if resentments clouded his thinking. And in business we will be open to many resentments if we get the idea that we are particular "big-shots" in that business, or in our office. The "bigger" we blow ourselves up to be in our own minds, the better the "target" for all with whom we come in contact. We must simply, in business, too,

adopt an attitude of humility which would tell us to "work with" others, and for others, and not demand always to work "over" others, not emphasize that we are "boss" or "the one who dictates the policy" or the "one who makes the decisions." Such type people seldom go very far in the business world; and, if alcoholic, they just *won't* go very far in the world of sobriety. The "boss" who lets all the world know he is the boss is a "sitting duck" for criticisms, etc. without end. You know them—*big* name-plates; name always qualified "*in charge*," "*manager*," etc. etc.; or unique eye-catching names: "*J. Jonathan Doe, Esq.*"

The successful business man? He has an honest knowledge of his limitations, doesn't "brag" about his acumen, but "uses" it instead; he has an *attitude of humility*. One never hears of his success save from somebody else. When he needs advice, he calls in an "expert" realizing his need.

"Words" or "criticisms" cannot throw out of focus what he himself knows of himself. He is seldom irritated.

The "failure"? No matter what actual success he might have had in business, to hear him tell it "day in and day out" *he SHOULD HAVE BEEN the most successful!* "Irritations"—"resentments"?—just contradict him and watch the explosion!

And if we are resentful of someone in our business, or office? There is only one answer—actions of love—*do* something *for* them.

4) *IN OUR FINANCIAL AFFAIRS.*

Resentments are costly! Remember when we "spent just for spite"? "I'll show 'em, I'll get even, I'll just *spend it all!*" And then just add up the "costs" on that last spree!

Whatever we have financially or materially, we *have it because God gave it to us*. That is honesty—that is an attitude of humility. You say you *worked* for it? Well, then, who gave you the ability, the opportunity, the health, etc., to do so? ? ? Hmmmmmmmmm?

This attitude will keep us from being too upset or irritated or hurt when we "lose" some money or material things. What was it Job said? "The Lord gave, the Lord hath taken away"!. No wonder he was so patient—or should we be "mad" at what the Lord does?

Then there is love: which tells us to *share what we have with those who have it not. Give!* That's what God gave it to us for. Particularly to those *whom we resent!* It works!

5) *IN OUR SPIRITUAL LIFE.*

Resentments, O resentments, we deplore—
If it weren't for resentments, we'd be
So happy and so holy—forever more!

"Lousy" poetry, but one of the greatest truths in the spiritual life, for it is our conviction that 99.99% of all spiritual woes and sins and failures *begin with resentment!* And the more we speak to people with spiritual problems and sins the more we see of *resentments*. And yet, on analysis we do not ever remember to having heard a talk, or sermon, or retreat conference on *resentments* that is until we came to A.A. And as the years pass above, more and more we can see *resentments* as the *CAUSE OF* and *SUBSTITUTION OF* most spiritual disintegration.

Let's look at a few:

a) Drinking, drunkenness, alcoholism—*usually took hold in the soil of discontentment, resentment.*

b) Philandering, divorce, etc.—*usually began in resentment, most men (and women) who started an affair with another woman (or man) FIRST became discontented with or resentful towards the other!* It was not usually because some "good looking lass" tempted one to follow. They *first* turned against or away from the wife—then anyone is a pushover for any "dame" that might happen along. Resentments pushed *love out*, and the vacuum drew lust in.

c) Laziness—resentment toward working or working as we must, or just towards life, albeit unconsciously. It is the background of every "loafer," of every neglect of duty, and of every just plain "bum."

d) Gluttony in eating—psychiatrists now tell us, and it is evident to those who have dealt with such, there are many who *over-eat just for spite, or* because of *boredom and discontentment and resentment.*

e) Jealousy—this passion *feeds* on resentment. Jealousy could never get hold without resentment coming first. (We speak not of "normal" jealousy, but of that "extreme type" which spiritual writers would label "sinful jealousy" and which psychiatry would call "abnormal"—it leads to revenge, etc. etc.)

f) Omission of prayers—how many who had such a good start in the spiritual life, gave up their prayers, and of course their spiritual living, *because of resentments....* "God never hears *my* prayers"—"For other people the birds *sing*"!

g) Quitting church—most such cases happen because of "what the pastor said, or did" or "some of the other members of the congregation said or did"... Resentments!

h) Giving up belief in God—because of the pathological resentment towards life, or men, or God....

All of which brings out into full view and gives a depth of new meaning to that saying of one of the philosophers centuries ago. His name was Plato: *"whom the gods would destroy, they first make mad"!*

The *prime enemy of alcoholics, the prime enemy of all spiritual life—RESENTMENTS!*

But you know something? We should have known that long, long ago. For it was long, long ago, when the Lord told us: "Thou shalt love the Lord thy God with thy *whole heart*.... this is the *greatest commandment.*" Then why should we not have realized

that the *opposite of love, which is hate and begins with resentments,* is the *most dangerous enemy to all spiritual life?*

6) *IN OUR EMOTIONAL LIFE.*

We can not tolerate resentments! How many ills and woes of the emotions—begin with resentments! Nervousness, upsets, tension, fears, and phobias of all types come when our emotions turn away from the realities of life and, because of resentments, seek outlandish outlets. The alcoholic? *The outlet,* the bottle! *"Let the other fellow get mad!" Expect criticism!* And all the "gimmicks" will rush in to help us attain and preserve an evenness of the emotions, *if* we *use* them, and *practice them*—day in and day out.

And *love?* It is, *when true,* the great leveller of life and emotion. That love which upsets emotion is not love but either infatuation or lust. *Actions* of love will rid our emotions of resentful tendencies—a "hangover" from our drinking days!

7) *IN OUR PHYSICAL LIFE.*

Ulcers and tiredness and migraine and allergies and "pains in the "neck"—and physical ills of every type, *come from resentment*—either conscious or subconscious. With the advent of psychosomatic medicine, it has been learned that more than 50% of the apparent physical distress comes from either known or hidden mental attitudes—mostly resentment. (Many such ills have been found to be from *discontentment—resentment against our role in life:* our profession, social status, nationality, even *our being a "man"* or a *"woman"!* More and more maladjusted people in marital relations are finding the *cause is resentment against living the role of "man" or "woman" which God has given to us.*)

Many people have actually cured a "pain in the neck" ("wry-neck" in medical language) by removing the cause, by changing their job and thus eliminating the boss or fellow worker who had *actually* been a *"pain in the neck."*

Many too, they say, have had heart attacks as a result of resentments. Under date of July 25, 1955, we read:

"*Philadelphia*—Want to avoid a heart attack. . . ? 'Avoid resentments,' Dr. David Gelfand stated here today.

"Dr. Gelfand heads the cardiac work evaluation unit at Philadelphia General Hospital and in 3½ years of careful study has examined 438 persons.

"He said 46% of the patients—each examined by a cardiologist, a vocational counsellor, a medical social worker and a psychiatrist—have a psychological factor present.

"*Resentment* that is not expressed or removed goes into the cardiovascular system, where it tightens the blood vessels. Continued insult to blood vessel tissue results in permanent hypotension—and then, a heart attack."

(Well that might be a comfort to us in A.A. Maybe many times those binges prevented a heart attack! ? ?)

In the alcoholic—a "bottle-attack"!

And now speaking of *love*—families who *practice actions of love* are proven to be the *healthiest families!* And who usually is healthier than a person in love?

8) *IN OUR THOUGHT LIFE.*

Mental aberrations, mental illness, forgetfulness, etc. etc., *come from resentments*—which cause retreat from reality. The answer? *Refuse TO RETAIN* the *thought.* And now then that *love* "business." "It's those we love we think about"—*lovingly!* No room for negative, resentful thinking! Simple, isn't it? ?

9) *IN OUR A.A. LIFE.*

Dissention in groups, slips, gossip, slander, splits, and what have you—all stem from *resentments.* To the alcoholic—*resentments*

retained mean drinking—there is no other answer. But how about those in the groups who seem to thrive on resentment: those who are constantly "mad at" or "against" something or someone? Well, they are "drunks" not alcoholics. They have not the "compulsive" factor of drink. They can remain resentful day in and day out—and stay sober. God bless them—He put them there for the rest who can not tolerate resentment, to have opportunity to practice patience, and kindness, and love—and to use "gimmick" after "gimmick" for protection until one achieves a *habit* of patience and tolerance and love! (Remember, there's at least *one* in every group.)

The alcoholic *cannot* tolerate resentment. That is why so much of the A.A. program is aimed at achieving those attitudes which will protect us from resentment—attitudes of *humility* ("there are no big-shots in A.A., no seniority, no graduation, etc., etc." "Anonymity" is to *give humility*); and attitudes of *love* ("this is a *give* program," "you don't have to *like* the "dope," but you can *love* him.")

Resentments, O resentments we deplore—
If it weren't for resentments, we'd be
So happy, and so holy *and so sober FOREVERMORE!*

And as a parting "gimmick": *It takes a REAL man and a REAL woman to LOVE; ANY "nincompoop" can hate!*

So, there you have it.

MH-26.5

SCHEME FOR PREVENTION OF ALCHOLISM AND SUBSTANCE (DRUGS) ABUSE.

APPLICATION FROM

1.Name and complete address of the organisation /institution/establishment and date of t establishment.

PROF.SIVARAMAN MEMORIAL TRUST,
47,CHINNIAH PILLAI ROAD,MARAVANERI,SALEM-7,TAMILNADU.

DATE OF ESTABLISHMENT: 8.9.1993.

2.Whether registered under societies registration Act,1860 or any other relevant act of the st Government/union territory Administration or under any other State Law relating to registrati of literacy,scientific and charitable socities or as public Trust and as a charitable company,if so

a)Give name of the Act under which registered: Registered under Tamilnadu Trust Act.
b)Registration No.and date of registration : 354/8.9.1993
An attested photocopy is enclosed.

3.Whether or not receiving foreign contributions,if so

a)No.and date of the registration certificate issued by the Government of India in the Ministry Home Affairs under the Foreigh contributions Regulations Act 1976.
(Please attach an attested photocopy thereof)

FCRA NO. and date of registration : 076000068 Dt 3.3.2000.

An attested photocopy is enclosed.

Our Organisation have not received any foreign contributions till date.

4.List of papers/statements attached.

a)Constitution of Board of Management/Governing body.etc and the particulars of e member(i.e. Name,Complete residential address,Parentage,Occupation with designation)

Separate sheet Enclosed.

The life of the Board of Management (i.e.the last date on which it was constituted and upt which date may also be indicated)
Enclosed
b)Constitution/Memorandum of Association and Byelaws of th Organisation/institution/Establishment.
Enclosed.
C) A Copy of the Annual Report for the previous year .
Enclosed.
d)A Copy of the Receipt and payments,Income and Expenditure and the Balance sheet for th previous three years certified by the Chartered Accountant or a Government Auditor.
Enclosed.
c) Detailed Budget Estimates with breakup of expenditure for which grant is required
Enclosed
d) Brief note indicating the sources of income,including foreign contribution,if any and al details of assets acquired during the previous three years.
Our Organisation have not received any foreign contributions till date.
Balance sheet and work plan are Enclosed.
5.Additional information,if any not covered by the above but relevant to the project may also submitted
NIL.

SIGNATURE

Dr.R.Anandkumar,Managing Trustee.
Name of the Organisation/institution/establishment with Office stamp.

Place:
Date:

BUDGET FOR SETTING UP 15 BEDDED TREATMENT -CUM-REHABILITATION CENTRE.

Sl.No	Name of the Post	No.of Posts	Monthly Exp.	Yearly Exp.
A.RECURRING EXPENDITURE(ESTT)				
a. Administrative				
1.	Project Director	1	7000	84,000
2.	Accountant cum Clerk	1	3000	36,000
3.	Sweeper/Chowkider	2	4000	48,000
b.Medical				
1.	Medical Officer (Part time)	1	5000	60,000
2.	Counsellor/Social worker/Psychologist	3	12,000	1,44,000
3.	Yoga/Other therapist	1	2000	24,000
4.	Nurse/Ward boys	2	6000	72,000
	Total A		39,000	4,68,000
B.RECURRING EXPENDITURE				
1.	Rent		12,000	1,44,000
2.	Medicines		6000	72,000
3.	Continengicies(stationery electricity postage,telephone etc)		5000	60,000
4.	Transport/Petrol & Maintenance of vehicle.		3000	36,000
	Total B		26,000	3,12,000
	Total A+B			7,80,000
C.NON RECURRING EXPENDITURE				
1.	20 beds,tables,3 sets of linens,blankets ,other office equipments			: 1,50,000

Total = 1,50,000+ 7,80,000 = 9,30,000.
10% Organisation contribution = 93,000
Total amount requested = 8,37,000.

STAFF MEMBERS FOR DRUG DEADDICTION CUM REHABILITATIO CENTRE.

The following staff members are appointed for the Drug Deaddiction cum rehabilitation centre

1.Project Director	:	Dr.R.Anandkumar
2.Accountant cum clerk	:	Mrs.K.Geetha
Educational Qualification		B.Com
3.Sweeper	:	Mrs.Manomani
4.Chowkider	:	Mr.Chellapan
5.Medical Officer	:	Dr.S.Balaji,MBBS
6.Counsellor	:	Miss.K.Geetha M.R.S.C,M.A Psychology Master of Rehabilitation Science Experience: Worked as a Counsellor for 6 months in Pudhu vazhvu. Drug Awareness counselling centre,salem-4 Worked as a Family Counsellor in Sahodari Family Counselling centre,salem.
7.Social worker	:	Mr.Karikalan
8.Physical & Yoga therapist	:	Mr.Muthu kumar, Qualification: C.P.Ed.
9.Nurse	:	Mrs. M.LAKSHMI, B.Sc Nursing
10.Ward boys	:	Mr.Mani,

COPY OF THE RESOLUTION

Date :

Place:

Subject	Resolution
Seeking Financial assistance for DRUG DEADDICTION CUM REHABILITATION CENTRE in Ministry of Social Justice and Empowerment in Salem District.	It is unanimously resolved that Prof.Sivaraman Memorial Trust w Apply for the scheme and abide b the terms and conditions of the scheme.
Appointing Managing Trustee as Project Director For this project.	It is unanimoulsy resolved that the Managing Trustee Dr.R.Anandkum Of PSMT will be the Project Director and getting all rights about The Project.

Dr.R.Anandkumar,Managing Trustee

Executive Members

S.Prema
[illegible] Padmini
[illegible] Lakshmi Ammal
C.Indirani
R.Sivakumar

JUSTIFICATION AND NEED OF THE PROJECT:

Salem is a place where alchol and other kind of drugs are more prevailing.Most of the men ar addicted to alchol and other drugs.As a result their family members are suffering including the children.Our PSMT is already doing Drug deaddiction counselling in and around Salem distri for the past three years,have decided to start a Drug De-addiction center in salem district.A such there is no Drug De-addiction cum Rehabilitation center in Salem district and other near places.We will be interacting with the Pudhu Vazhu maiyam,which is a Governme Counselling center in Salem district.We have conducted a lot of Awareness programme in dr deaddiction in and around Salem district.Now we have rented a suitable place for running t Drug De –addiction center in salem district.Necessary alterations have been made in the buildi to run a Drug de-addiction centerWe have also appointed the necessary st members,counsellor,Medical faculties with necessary qualifications and Training and all t other arrangements are being made to run a Drug De-addiction center.The informatio regarding the survey and other details are collected from the Pudhu vazhu maiyam,counselli center,salem and we have enclosed the case sheet model and Questionnarie for intervention C Staff members have undergone the necessary Training in Kajamalai Drug De-Addiction ce Rehabilitation center,Trichy.The Training certificates are Enclosed for your reference T Rental deed for the Drug de-addiction center for 11 months is also enclosed.List of st members appointed for the Drug de-addiction center are also enclosed.We have purchased t necessary Books on counselling,Drugs and other Books for our reference Being a Medi faculty and with an experience in this drug de-addiction programme for 3 years,and hav already the necessary staff members to run the programme,it is justifiable for our Organisation run a Drug De-addiction center in salem district.

STAGES AND MODALITIES OF TREATMENT

1.Identification and screening the addicts.
2.Motivation for treatment.
3.Treatment-Medical and Psychological
4.Rehabilitation

TREATMENT

1.Medical:

a.Detoxification
b.Control of with drawal symptoms
c.Body restructuring
d.Aversion therapy-Disulfrim treatment.

2.Psychological treatment

a.Individual counselling
b.Group therapy
c.Family therapy
d.Yoga and exercise therapy.

Follow-up

Follow –up will done in Medical and psychological treatment

AA (Alcholic Anonymous)

Forming an association of Ex addicts and others for improving their self confidence.

PROF.SIVARAMAN MEMORIAL TRUST

MARAVANERI, SALEM-7

DRUG DE-ADDICTION CUM REHABILITATION CENTR

Social worker Counsellor: Psychatrist:

Registration No: Follow up No:

Date of Admission : Date of Discharge:

Name : Age: Sex:

Father's Name:

Address: Reffered By:

Mother tongue: Religion :
Marital Status: Educational Status:
Occupation: Income:
Diagnosis:

Drug History :

Drug	Dose	Duration	Year	Treatm

Informant

Client

Present complaints:

Client Informant:

Reasons for Abusing Drugs:

Client : Informant:

PAST HISTORY

	Duration	Year	Treatment
Physical illness:			
Mental illness :			
Suicide Attempt:			

PERSONNEL HISTORY

Delivery : Feeding : Birth Order:

Developmental Mile stones:

Upbrining Day Time care:

Childhood disorders: Fears/Phobias:

PREMORBID PERSONALITY:

Chronological History	5 to10	10 to 15	15 t0 20	Above 20
Scholostic Achievements				

Aspiration

Hobby

Play

Habit

Extracurricular activities

Sociability with

Neighbours

Relatives

Friends

Organisations

Clubs

Significant

Events

OCCUPATIONAL HISTORY Present position Income

Age	Jobs Held	Reasons for change	Satisfaction	Dissatisfaction

SEXUAL HISTORY:

Puberty: Age of Onset: Menstruation:
Sex Knowledge at the age of : Masturabation:

Pre marital experience:

MARITAL HISTORY:

Age : Love/arranged/forced ; Age at the birth of first child:

Spouse: Age: Education: Occupation: Personality:

Children: Born: Alive: Died : Pregancy/Abortions:

Adjustement: Reasons for maladjustment:

1. 2. 3.

4. 5. 6.

Sexual Relations:

Disorders:

Extramarital Experience:

History of family illness: Mental illness:

Addiction : Suicide Attempt:

FAMILY HISTORY

Type of Family: House : Neighbours:

Relations Between: Father/Mother Siblings:

Client/Father Client/Mother:

Family Client/In-laws

No.	Name	Relation	Age	Sex	Education	Occupation	Income	Personali

PHYSICAL STATUS:

Weight | Height | Body Built
General | B.P | Pulse

Systems:
CVS
RS
CNS
ABD
OTHER

MENTAL STATUS:

Generral Appearance:

Attitude:

Orientation:

Memory:

Thinking:

Perception:

Mood:

Intelligence:

Insight:

Judgement:

Motivation:

PRESENT PROBLEMS:

School	Sexual	Familial	financial	Occupation

FAMILY THERAPY

DATE	SUBJECT	COUNSELLOR	FAMILY MEMBER	REMARKS

Psychiatric Social Worker report

GROUP THERAPY

DATE	NO.OF SESSIONS	SUBJECT	PSYCHIATRIC SOCIAL WORKER	REMARKS

HOSPITAL

FOLLOW - UP CARD

Name of the patient :

Date of admission :

Occupation :

Address & Phone :

a) Residence :

b) Work Place :

Reg. No :

Age : Marital Status :

Name of Wife / Mother :

Type of drugs abused :

Duration of abuse :

TTR / Self-Payment / Company :

Medicines on discharge :

- Disulfiram / Disulfiram P
-
-
-

Counsellor :

Date/ Month	Sober/ Relapse	Counselling	Details of Communication	Date/ Month	Sober/ Relapse	Counselling	Details of Communication

Name of support persons with address and phone No.:

Residence :

Work Place :

1.)

2.)

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HIGH RISK SITUATIONS / LIFE STYLE	YES	NO
Family member living with him drinks		
Drinking in the work environment		
On shift duty		
Travelling on work frequently		
Lives alone		
Having EMR at present		
Problem gambler		
Unemployment		
Any other		

CHARACTER DEFECTS	NIL	MILD	MODERATE	SEVERE
Perfectionism				
Grandiosity				
Impulsiveness / Impatience				
Over sensitive				
Lazy				
Arrogance / Defiance				
Selfishness				
Anxiety				
Anger				
Lack of assertiveness				
Withdrawn				
Denial				
Any other (specify)				

ISSUES IN FOLLOW-UP	YES	NO
Non-availability of AA in home town		
Lack of resources to come for follow-up		
Inability to get leave / not able to leave work		
Any other (specify)		

Referral to ACC / Any other Centre / Vocational Therapy :

Presence of co-morbidity (Specify) Present Absent

1.) Medical problems
-
-
-
-

2.) Psychiatric problem (specify)
a) Depression
b) Mood disorder
c) Psychotism
d) Personality disorder
e) Any other

Debts - Amount

Issues in family relationship

Patient's level of involvement	V.Poor	Poor	Average	Good	Excellent
Family's support	V.Poor	Poor	Average	Good	Excellent
Prognosis	V.Poor	Poor	Average	Good	Excellent

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Hospital

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

IN-TAKE FORM

Regn. No. :

Counsellor's Name :

1. Name in BLOCK letters :
2. Date of :

   Admission at detox ward :

   Admission at therapy ward :

   Discharge :

3.

Sex	Year of birth	Age	Religion	Caste

Religion:

Hindu	=	H
Christian	=	C
Jain	=	J
Muslim	=	M
Parsi	=	P
Any other	=	Z

Caste:

Forward Caste	=	F
Backward Caste	=	W
Scheduled Caste	=	C
Scheduled Tribe	=	T

4. Years of education (Mention only no. of years) : .....

Illiterate	=	0	M.Phil, Post Graduation in Engineering, Medicine	=	19
1 to 12	=	1 to 12			
B.A.,B.Sc.,B.Com.	=	15	Ph.D.	=	22
B.L., B.Ed.	=	17			
M.A.,M.Sc.,M.Com., Medicine, Engineering Accountancy					

5. **Qualification**

Primary & Secondary	=	A	Accounts	=	I
Higher Secondary	=	B	Law	=	J
Graduate	=	C	B.Ed.	=	K
Post Graduate	=	D	Diploma in	=	L
Pre-Doct., Ph.D.	=	E	MBA	=	M
Engineer	=	F	Any Other	=	Z
Medicine	=	G	Not applicable	=	NA
PG Medicine	=	H			

6. Can read and write
   Can only read
   Cannot read and write

7. Permanent address:

   Telephone No.
   Patient Res.:
   Off. :
   Family Off. :
   Email:

8. Contact Person: Local address (for emergency)

   Telephone No.
   Off. :
   Res.:

9. Names and addresses of two support persons with telephone Nos., indicate relationship:

   i) Telephone No.
   Email:

   ii) Telephone No.
   Email:

10. Living Arrangements :

Reside in family units (parents / spouse / children / siblings)	=	A
Live with friends or distant relatives	=	B
Live alone (own place, lodge) Details	=	C
Institutional arrangements - Details :	=	D
Transient - Details :	=	E

11. Urban (U) / Rural (R)

12. Language which you are most comfortable with (indicate I & II priorities)

Tamil	=	T	Marathi	=	R
Hindi	=	H	Gujarathi	=	G
Malayalam	=	M	Telugu	=	L
Kannada	=	K	English	=	E
Urdu	=	U	Oriya	=	O
Bengali	=	B	Any Other	=	Z

13. Language which your family member is most comfortable with (indicate I & II priorities)

Tamil	=	T	Marathi	=	R
Hindi	=	H	Gujarathi	=	G
Malayalam	=	M	Telugu	=	L
Kannada	=	K	English	=	E
Urdu	=	U	Oriya	=	O
Bengali	=	B	Any Other	=	Z

14. Marital Status

Married	=	M
Single	=	I
Separated	=	T
Widower / Widow	=	W
Divorced	=	D
Any Other (living together without marriage)	=	Z

15. Occupational Status

Employed full time	=	E
Employed part time	=	P
Unemployed	=	U
Retired	=	R

16. Occupation Type

Unskilled /Semi Skilled Labour	=	U	Teacher	=	T
Skilled Labour	=	K	Farmer	=	F
Tailor	=	O	Defence Services	=	D
Executive	=	E	Housewife	=	H
Business	=	B	Social Worker / Psychologist	=	P
Student	=	I	Clerical	=	C
Lawyer	=	L	Doctor	=	M
Engineer	=	G	Retired	=	Q
Sales Representative	=	R	Any Other	=	Z
Accountant	=	A	Not Applicable	=	NA

17. Income per month

18. Place of employment
Name & address

19. Prior treatment for addiction Yes No
If yes,

	Year	Duration of Treatment (days)	Period of Abstinence (days)	Name of the place/ Doctor
Treatment at TTR = T Other Addiction Centres = A Psychiatrist (In / out-patient basis) = P At General Hospital = G At Nursing Home = H Traditional Treatment = D Any Other = Z				

20. Any previous attempts to abstain from alcohol / drugs for more than two weeks (Other than organised help for example, pilgrimage, self-effort, etc.).

Year	Periods of abstinence	Method used	Motivating factor (any crisis)

21. Referral :

Family / Wife	=	W	Physician / Specialist	=	P
Employer	=	E	Mental Health Professional	=	H
Recovered Alcoholic	=	A	Friend	=	F
Media / awareness programme	=	M	Government Hospital	=	G
Self	=	I	Any Other	=	Z

22. Diagnosis :

Alcoholism	= A
Drug Dependence	= D
Alcohol and Drug Dependence	= AD
Poly Dependence	= PD

FAMILY HISTORY

Details regarding parents (if alive)

23. Father's age : Occupation :

24. Mother's age : Occupation :

(if not alive)

Reason for death - Father :

Mother :

25. In case of death of parents,how old were you at that time?

Father's death : .... years

Mother's death .... years

Not applicable = NA

26. Details regarding siblings (write according to the order of birth)

Relationship	Age	Education	Occupation	Remarks

27. Order of Birth

First	=	1	Only Child	=	0
Middle	=	2	Only male	=	4
Last	=	3			

28. Health Status of Family

Has there been anyone in your family who has suffered from any of these problems?

Problems		I Degree Parents & Siblings				II Degree Grand Parents Parents' Siblings			
		Yes	Relation	No	Don't know	Yes	Relation	No	Don't know
Major Depression	= M								
Suicide / attempted suicide	= U								
Psychiatric illnesses	= P								
Alcohol Dependence	= A								
Drug Dependence	= D								
Gambling	= G								
Any Other	= Z								

In the case of addiction, not to include social drinkers or occasional drinkers. Addicts are those who have had one or more of these problems.

Marital / job / legal problems ; Alcohol withdrawal symptoms; Physical impairment ; Blackouts ; Social disapproval

29. Were there any deaths in your family due to alcoholism / drug dependence?

Yes No

If yes, indicate relationship.

Relationship = I Degree II Degree

PERSONAL HISTORY

30. Did you experience the following before the age of 15 years?

Situations	Code	Present	Absent
- Poverty / severe debts / sudden economic changes	A		
- Parental loss	B		
- Separation from parents	C		
- Extra-marital affairs of parents	D		
- Broken home / single parenting	E		
- Frequent family conflicts	F		
- Violence in the family	G		
- Punitive parenting (too strict and punishing)	H		
- Any other	Z		
- None			

31. Childhood / Adolescence (before the age of 15 years)

Behaviour problems Identified	Code	Present	Absent
Truancy	A		
Running away from home	B		
Frequent physical fights	C		
Forced someone into sexual activity	D		
Cruelty to animals	E		
Physically cruel to other people	F		
Destruction of others property	G		
Lying frequently	H		
Stealing	I		
Scholastic backwardness	J		
Excessive indulgence in money / movies	K		
Experimenting with drugs / alcohol	L		
Gambling	M		
Any Other	Z		

32. Achievements identified

Present Absent

Responsible - A
Good academic records - B
High achiever - C
(Extra curricular activities)

33. The relationship with parents and significant others during childhood as perceived by patient.

34. Anti-social personality during adult life :
(Presence of 4 or more before the onset of problem drinking)

	Code	Yes	No
Unable to continue with job / school (repeated absences or resigning job without planning / 6 months of unemployment)	A		
Involving in unlawful activities-stealing, destroying property, harassing others, illegal occupation.	B		
Irritable, aggressive (including spouse and child beating)	C		
Failure to honour financial obligations	D		
Impulsive behaviour (leaving home without any plan, no address).	E		
Repeated lying	F		
Drunken driving, recurrent speeding	G		
Inability to function as a responsible parent (not providing medical care, not providing for basic needs, repeated squandering of money)	H		
Inability to sustain monogamous relationship	I		
Lacks remorse (feels justified in hurting, stealing, etc.)	J		

HISTORY OF ALCOHOLiSM

35. How old were you when you had your first drink? .....

36. How many years were you drinking regularly (at least once a month) without any problems .....

37. How many years has your drinking been creating problems? .....

38. Describe below the pattern of alcohol use :

If possible demarcate 2 or more stages of drinking in chronological order, starting with the recent past. It is important that atleast the recent pattern of drinking should be described :

Type of Beverage	Frequency Day/Month	Total Quantity in a day	Duration in years

Type of beverage			Frequency		
Beer / Toddy	=	T	Once a fortnight	=	1
Wine	=	W	Once a week	=	2
Brandy / Rum / Whisky / Gin	=	R	2-3 times a week	=	3
Arrack	=	A	4-5 times a week	=	4
			Once a day	=	5
			Twice or more a day	=	6
			Binge	=	7

Quantity	1/4 bottle / 3 pegs / 1 pkt. of arrack	= 1
	1/2 bottle / 6 pegs / 2 pkts. of arrack	= 2
	3/4 bottle / 9 pegs / 3 pkts. of arrack	= 3
	1 bottle / 12 pegs / 4 pkts. of arrack	= 4
	More than 1 bottle	= 5

39. Malt - Munich Alcoholism Test (Tick True or False) :

	True	False
a. My hands have been trembling a lot recently.		
b. In the morning I sometimes have the feeling of nausea		
c. I have sometimes tried to get rid of my trembling and nausea with alcohol		
d. At the moment I feel miserable because of my problems and difficulties		
e. It is not uncommon that I drink alcohol before lunch		
f. After the first glass or two of alcohol I feel a craving for more		
g. I think about alcohol a lot		
h. I have sometimes drunk alcohol even against my Doctor's advice		
i. When I drink a lot of alcohol, I tend to eat little		
j. At work I have been criticized because of my drinking		
k. I prefer drinking alone		
l. Since I have started drinking I have been in worse shape		
m. I have often had a guilty conscience about drinking		
n. I have tried to limit my drinking to certain occasions or to certain times of the day		
o I think I ought to drink less		
p. Without alcohol I would have fewer problems		
q. When I am upset, I drink alcohol to calm down		
r. I think alcohol is destroying my life		
s. Sometimes I want to stop drinking and sometimes I don't		
t. Other people can't understand why I drink		
u. I have sometimes tried to get along without any alcohol at all		
v. I would get along better with my spouse if I didn't drink		
w. I'd be content if I didn't drink		
x. People have often told me that they could smell alcohol in my breath.		

To be assessed by the Physician

a. Diseases of the liver (at least one symptom found on physical examination in addition to one positive laboratory test) Yes No

b. Polyneuropathy (only if no other cause is known, e.g., diabetes mellitus) Yes No

c. Delirium tremors (on the present examination or previously) Yes No

d. Alcohol consumption of more than 150 ml (women 120 ml) of pure alcohol a day at least continued over several months Yes No

e. Alcohol consumption of more than 300 ml (women 240 ml) of pure alcohol at least once a month (alcohol benders) Yes No

f. Foetor alcoholicus (at the time of medical examination) Yes No

g. Spouse, family members or good friends have sought help because of alcohol related problems of the patient (e.g. from a physician, social worker or other appropriate source) Yes No

Score of MALT =

Questionnaire	- 1 point for each 'True' answer
Medical component items	- 4 points for each 'Yes'
Less than 6 points	- no evidence of alcoholism
6 - 10 points	- suspicion of alcoholism
11 or more	- alcoholism

DETAILS OF DRUG TAKING

40. Record all details about drugs abused (exclude alcohol) :

Drugs	Age of first use	Years of excessive use	Specific type of drugs	Route of administration	Frequency of use in the past 6 months	Quantity used in the past 6 months	Past use if any	Primary / secondary
Depressants Tranquilizers, sedatives / Hypnotics								
Narcotic Analgesics Opium, Heroin / brown sugar, Morphine, Codeine, Pentazocine Buprenorphine								

Drugs	Age of first use	Years of excessive use	Specific type of drugs	Route of administration	Frequency of use in the past 6 months	Quantity used in the past 6 months	Past use if any	Primary / secondary
Cannabis Ganja, Charas, Bhang								
Stimulants Amphetamine Cocaine								
Hallucinogens LSD, PCP								
Inhalants Petrol, Glue								
Substance not classified Cough syrup, Anti histamine / Anti depressant / Anti psychotic / Anti cholinegic								

(Frequency of use codes)

Never used	= 0	2-3 times a week	= 3
Once a fortnight	= 1	4-5 times a week	= 4
Once a week	= 2	Once a day	= 5
		Twice or more a day	= 6

Route of administration

oral	= 1	Inhalation	= 3
Smoking/chasing	= 2	Intra muscular	= 4
Intravenous	= 5	Not Applicable	= NA

41. If the patient is an IV user, frequency of sharing practices

Sharing practices	Never - N, Rarely - R Occasionally - O, Frequently - F
Needle	
Needle and syringe	
Paraphernalia	
Drugs	

42. Score of DAST

43. Other compulsive behaviour (within 5 years)

Compulsive behaviour	Frequency	Circumstances
Gambling (cards, betting on horses, lottery)		
Casual sex		

Frequency	Circumstances
N - Never	N - Never
R - Rarely	A - Only under the influence of alcohol
O - Occasionally	B - only when not drinking
F - Frequently	C - Both

44. Tobacco Use:

Tobacco		Yes	No
Smoking	= S		
Chewing tobacco / snuff	= T		
Pan Parag	= P		
Zarda Pan	= Z		

OCCUPATIONAL HISTORY

45. At what age did you start working? .....
Not Applicable = NA

46. How long have you been working?.....

47. Did you change your job frequently due to drinking? Yes No

If yes, how many jobs have you changed in the last 10 years due to drinking?

48. Did you have any periods of unemployment in the last 5 years? Yes No

If so, for how long and for what reasons?

49. Specify nature of current work:

50. Have you been subject to the following?

Business/ Agriculture		Impact of addiction on work		Regular Employment	
Yes	No			Yes	No
		A - Absenteeism	= A		
		Warning / Memos	= B		
		Suspension order	= C		
		Dismissal order	= D		
		Transfer order	= E		
		Loss of pay	= F		
		Accidents on the job	= G		
		Deterioration in quantity & quality of work	= H		
		I - Attend work under the influence of alcohol	= I		
		J - Not fulfilled financial/ other commitments towards employees			
		K - Closed down business, faced major loss or given on lease			
		Not applicable	= NA		

51. Have you received any special award, recognitions, merit certificates or promotions?

Yes No

52. Occupational damage (as perceived by the Counsellor) Mild Moderate Severe

59. Financial damage as perceived by the Counsellor. Mild Moderate Severe

60. The impact of financial problem on patient/ family / others.
Provide details.

MARITAL HISTORY

61. Details regarding spouse:

Name
Age
Religion
Education
Occupation
Income
Not Applicable = NA

Other details about spouse (history of addiction in her family, her drinking history, any other significant event in her life, attitude towards drinking, etc.)

62. No. of years of marriage

63. Is this marriage arranged or by choice?

Arranged = A Choice = C

If by choice, accepted by family (present status) Yes No
if no, give details

64. Details regarding previous or subsequent marriages of patient, if any Yes No
(If yes, provide details)

65. Health status of spouse / children

		Spouse	Children
Major depression	= M		
Suicide or attempted	= U		
Psychiatric problems	= P		
Alcohol Dependence	= A		
Drug Dependence	= D		
Mental Retardation	= R		
Childhood behaviour disorder (conduct disorder, attention deficit, school refusal)	= C		
Not Applicable	= NA		

66. Have you been separated due to your drinking? Yes No

If yes, No. of times separated .....
Longest duration of separation .....
Not Applicable = NA

67. No. of children

Age	Sex	Education	Occupation	Income	Marital Status	Behaviours Problem If, any

68. If there are no offsprings, state reasons:

Medical Reasons	= A
Due to drinking	= B
Personal choice	= C
Married for a short duration	= D
Any other	= E

69. Is patient suspicious of wife?

While drinking		During abstinence	
Yes	No	Yes	No

If yes, details

Not Applicable = NA

70. Any instances of family violence?
(please indicate N = never, R = rarely, O = occasionally, F = frequently).

		While drinking	During abstinence
Physical violence directed towards spouse / children/ parents / siblings	A		
Verbally abusive	B		
Violent incidents with neighbours and outsiders	C		
Breaking articles at home	D		

71. Damage to the family system as perceived by the Counsellor.

Mild Moderate Severe

SEXUAL HISTORY

72. Record pre / extra marital experiences — Present / Absent / N/A
If sustained relationship is present
- Age of partner:
- For how many years have you known each other?
- What is the living arrangement?
  - Separate house
  - Both wives live together
  - Lives with her parents
  - Lives with her husband / children
  - Any other
- Any children through patient — Yes / No / Details

73. Have you been involved in any high risk sexual activities?

Sex with commercial sex workers		Yes	No
If yes, did you use condoms	Always	Sometimes	Never
Sex with casual acquaintance		Yes	No
If yes, did you use condoms	Always	Sometimes	Never

74. Have you been tested for HIV? Yes / No

If yes,
Positive / Negative
Not willing to reveal
Not collected Reports
Not Applicable = NA

75. At present do you have any sexual problems? Yes / No / N/A
If yes,

Reduced libido	=	R
Impotency	=	I
Excessive sexual urge	=	E
Complete abstinence	=	C
Any deviant behaviour	=	Z

LEGAL HISTORY

76. Have you driven a vehicle under the influence of alhocol? Yes / No
If so, No. of times .....
- Stopped by police
- Arrested / fined
- Had an accident (major or minor)

77. Have you got into trouble with law for the following? Yes / No
- Assault
- Possession of drugs
- Pushing drugs / sale and production of alcohol
- Any other crime

78. Inter-personal relationship (present status)

Relationship with spouse children, parents, siblings		Spouse	Children	Parents	Siblings
No family (dead or living distant)	= A				
Disowned by family or vice versa, mutual rejection	= B				
Mixed or indifferent feelings	= C				
Usually friendly, minor conflicts	= D				
Supportive	= E				
Not applicable	= NA				

79. Leisure time activities or hobbies:

Record: never.= N, rarely = R, occasionally, = O, frequently = F.

Activities		Before	After
Playing Games, Physical exercises	= A		
Going to movies, dramas	= B		
Watching T.V. / Video, listening to music	= V		
Reading	= L		
Visiting and entertaining parents, siblings other relatives friends	= I		
Hobbies / talents (playing music painting, etc.)	= H		

RELIGIOUS BELIEFS

80. Are you a

- believer = B
- non believer = E
- indifferent = I

81. Do you (record never = N, rarely = R, occasionally = O, frequently = F

Visit temple = A .....
Go on pilgrimages = B .....
Celebrate festivals = C .....
Have prayer at home = D .....

CONSENT FORM

The following information has been explained to me :

1. The possible consequences of any intake of alcohol while on disulfiram.
2. The side effects of disulfiram.
3. I am hereby informed that should I ingest even a small amount of alcohol while taking disulfiram, I will probably experience a highly unpleasant reaction consisting of flushing, palpitation, vomiting with a possibility of aspiration. I am hereby informed that a fatal reaction as a result of consuming alcohol while taking disulfiram is a possibility.

Knowing and having been informed of the risk involved as noted above, I agree to refrain from the use of alcohol.

I hereby accept the full responsibility of taking disulfiram.

Signature of the patient

Signature of a
responsible person / relative

Address of the responsible person / relative

ஒப்புதல் பத்திரம்

கீழே கையெழுத்திட்டுள்ள எனக்கு கீழ்கண்ட விஷயங்கள் விரிவாக எடுத்துச் சொல்லப்பட்டன :

1. 'டைசல்பிரம்' மருந்து சிகிச்சையின் போது மது அருந்தினால் ஏற்படக்கூடிய விளைவுகள்
2. 'டைசல்பிரம்' மருந்தின் விளைவுகள்
3. 'டைசல்பிரம்' மருந்து சிகிச்சையின் போது நான் சிறிதளவே மது உட்கொண்டாலும் எனக்கு முகம் சிவத்தல், நாடி துடிப்பு அதிகமாதல், வாந்தி எடுத்தல், மூச்சு திணறல் போன்ற பாதிப்புகள் ஏற்படலாம். மேலும் இதனால் அபாய நிலையோ அல்லது இறப்போ ஏற்படலாம் என்பதை எனக்கு எடுத்துக் கூறப்பட்டுள்ளது.

மேற்கண்ட அபாய விளைவுகளைப் பற்றி எடுத்துக் கூறப்பட்டதன் மூலம் நான் அவற்றைப் பற்றித் தெரிந்து கொண்டதால் டைசல்பிரம் மருந்து சிகிச்சையின் போது மது அருந்தாமலிருக்க ஒப்புக் கொள்கிறேன்.

டைசல்பிரம் மருந்து சிகிச்சைப் பற்றி முழுப் பொறுப்பையும் நான் ஏற்றுக் கொள்கிறேன்.

நோயாளியின் கையொப்பம்

நோயாளியைச் சார்ந்த பொறுப்பாளர்
உறவினர் கையொப்பம்

பொறுப்பாளர் / உறவினர் / விலாசம்

THERAPY CHECK LIST

Month / year of admission

1. Name of the Patient

Regn.No

2. Name of the Counsellor

3. Diagnosis A D AD PD

4. Participation in family programme Good Average Poor
   Wife
   Father / Mother
   Children
   Other family members
   If the family did not attend 50% of family programme, state reasons

5. Support person Present Absent
   Active involvement of support person (during treatment) Good Average Poor
   Relationship of support persons
   (check if you have written the names and addresses - 'very important')

6. Indicate N = Never, R = Rarely, O = occasionally, F = Frequently

Behavioral observations		At admission		At discharge	
Restlessness	A				
Irritability	B				
Not attending / coming late for classes and counselling	C				
Demanding	D				
Critical of facilities	E				
Argumentative and aggressive	F				
		Yes	No	Yes	No
Reluctant to change	G				
Drinking while on outpass	H				
Experimenting with drugs / alcohol on premises	I				
Planning future drinking	J				
Not willing to take Disulfiram	K				

7. Denial on admission Nil Mild Moderate Severe
   Denial on discharge Nil Mild Moderate Severe

MOTIVATION AT DISCHARGE

Behavioural observations	Total	Partial	Nil
8. Acceptance of alcohol / drug addiction as problem			
9. Presence of guilt / remorse about consequences of drinking			
10. Acceptance of total abstinence as a goal			
11. Willing to take disulfiram			
12. Willing to make changes in oneself			
13. Recovery is hindered by severe physical problem.			
14. Recovery is hindered by psychiatric problem.			
15. Recovery is hindered by lack of family support			
16. Recovery is hindered by severe financial problem.			

17. Additional indicators: Yes No

Referral by Employer
Exposed to AA meetings
Past history of abstinence
Short duration of addiction / early phase

18. Attitude of patient towards programme

Excellent co-operation
Moderate co-operation
Low co-operation
Non co-operation / drop out

19. In case of drop out, give reason

Physical / Pschiatric problems - A
Inadequate motivation - B
Inability to get leave - C
Lack of family support - D
Legal problems - E
Any other - Z

20. In case of extension beyond one month, record period of extension and reasons for extension

VERY IMPORTANT

21. Please fill up this column. In case of 'no news' we need two addresses other than that of patient for contact.

Name and Address	Telephone	Relationship

22. Baseline data with regard to patient's functioning at the TIME OF DISCHARGE

Physical well being	1	2	3	4	5
Gainfully employed	1	2	3	4	5
Financial stability	1	2	3	4	5
Crime free	1	2	3	4	5
Healthy relationship with family members	1	2	3	4	5

23. Recovery Status at the end of SIX MONTHS

Alcohol / drug free life	0	1	2	3	4	5
Physical well being	0	1	2	3	4	5
Gainfully employed	0	1	2	3	4	5
Financial stability	0	1	2	3	4	5
Crime free	0	1	2	3	4	5
Healthy relationship with family members	0	1	2	3	4	5

24. Recovery status at the end of ONE YEAR

Alcohol / drug free life	0	1	2	3	4	5
Physical well being	0	1	2	3	4	5
Gainfully employed	0	1	2	3	4	5
Financial stability	0	1	2	3	4	5
Crime free	0	1	2	3	4	5
Healthy relationship with family members	0	1	2	3	4	5

Counselling Notes:

Session No. & Date	With whom	Key issues dealt with

Summary

1. Demographic details
2. Family background (family of origin)
3. Alcohol / drug use history
4. Medical history
5. Occupational history
6. Financial situation
7. Marital history
8. Social support available
9. Counsellor's impression
10. Short and long-term goals

MH - 26.9

I have the Honour and privilege to present this paper on "Drug-Abuse prevention and Treatment of the Drug addicts and camp approach" undertaken of Manaklao De-addiction centre and Mobile camps before the honourable delegates of FINGO-DAP.

The history of Drug abuse in India is very old, because in India drug-use is well knit with her cultural and traditional heritage. In old days there was common use of SOM-RAS (सोमरस) (essence derived from the natural herb) and in later on the Som-Ras was substituted by the BHANG/GANJA/CHARAS and OPIUM. The Bhang, Ganja and Charas became popular in Faquirs, Baba and Saints (Maditational-class), whereas the opium in its different shapes and varieties became much more popular in Rural and Urban Class. Mostly it is being taken in solid state, liquid from or smoking as Madak or chandu etc. etc.

Gradually opium-use became the part of Cultural and Royal tradition. The warriors of old days used it as a medicine while fighting in battle-field and Rajputs were the formost class to join armies, thus opium-spread was commonly seen in West Rajasthan, which has long rooted in families, generations after generations, and became a symbol of social custom. There are community meets called as "RIYONS" or Hathai where people assemble and opium is offered amongst each other. The refusal is taken as dishonour of the Hathai and enemity starts. In various social occasions or family customs just as-pleasure, on child birth (boy), purchase of cart, land or property etc., engagement or marriage ceremonies, removal of old enemity (राजिपा) or call for unite to face battle (लड़ाई) or on the

occasion of death of a person. It is seem in poor working class that working mothers use to give a piece of opium to an infant to keep him under sleep so that she may be free to do labour.

The values of life gradually changed, so as with time the traditional drug abuse is changed. The taste of drug-demand diverted from opium to Barbaturates, Sadatives Heroin, Smack (Brown Sugar) etc. and young boys and girls of big cities and from affluent families begane to use this drug. The present average is 20 to 40% of the youngster who are dependent of these dangerous drugs.

INCEPTION OF CAMP APPROACH IN TREATMENT OF ADDICTION

(A) Origin

The belief that, it is rather impossible to give-up opium in ones lifetime, is creation of pushers and it gained momentum by the failure of adequate treatment of detoxification in Government hospitals and institutions. Hence addition of drugs grabed rural population day by day.

In the year 1978 Government of India launched a programme for uplift of persons living below poverty line and loaned amount to various persons for self employment i.e. purchasing Livestock. But all were squandred away only to sustain daily opium or drug consumption. The auther of this paper, a former University-lecturer and than Mayor (Sarpanch) of the village MANAKLAO realized the seriousness of the drug-abuse problem. His constant meet with local Doctor Mr. B.R. vyas, member of the addict's families, philanthropic societies and addicts themselves, could help him to conceptualise

the plan to start a treatment-means to detoxify those persons and to eradicate opium abuse dependency. The auther came forward and started First-Deaddiction Camp in the Year 1979, at Manaklao and Dr. Vyas stood with him as medical expert.

(B) Method of Treatment :

The method of Camp treatment-service has its unique technique and the way of handling, the addicts who are taken under treatment, is also uncomparable. No addict in de-addiction camp is taken as a patient but is accepted as sufferer of social evil. Thus the difference in the treatment between hospital or Medical Institute and Drug de-addiction Camp is quite obvious. Hospitals believe in a system of treatment, where as in de-addiction camps concentration is given on S.O.S., and each addict is served individually. A hospital could treat a patient, when de-addiction camp helps and addicts to get himself relieved from the habit of drug abuse through Love, Affection, Selfless service, dedication, religious, spritual and emotional touch, along with needed medical aid. The Camp treatment therapy has given grand success in its results.

But one basic point is that whosoever is willing to be relieved from drug dependency, writes himself case history of his own, along with his postal address. His name is registered in Registration record and when de-addiction Camps are organized there registered addicts are invited and admitted for detoxification.

(C) The bound daily working programme of De-addiction Camp.

One de-addiction camp runs for 10 days at de-addiction center but in mobile camps the duration is for 15 days. When camp started the burning problem was a opium dependency and limitation was up to Rajasthan only, but later days many addicts came who were addicts of Mendrex, Chandu, Madak, Ganja, Heroin and Doda (Dried cells of opium fruit). The careful observation of behaviour and accepting-attitude towards the camp therapy of these addicts could give us wide experience to detoxify them at minimum pains and troubles. This successful treatment of various drug-abusers of different economic-class gave us chance to organize a Smack-detoxification camp at Delhi in Kanjhawala village 33 Km. Away from city on Nangaloi Road. Its further success compelled us to held a de-addiction camp at Bangalore.

Now the camp strategy of 10 days, treatment is putforth for detailed information :–

First day is the medical checkup & admission day; because history of every addict which is already kept in record gives the real picture of his habits, behaviour, attitude and health. After check-up and admission for de-toxification treatment the period of 9 days is devided in three phases.

First Phase is of three days i.e. 2nd, 3rd & 4th day. In this period addict gives-up the drug-dose and falls to severe physical withdrawal symptoms, which differs from man to man due to his bodily and mental tendencies. By the Second and Third day Insomnia, Anxiety, Vomiting, Diarrhea, Body-pains, Crams in limbs, Muscular, Abdominal and Chest-pains develop, which upset the mental balance of addict and he starts to act under nervousness.

Some times even blood-pressure goes down and an addict comes to collapsive condition. These are the days when Doctors, Nurses and Social workers and deaddicted volunteers service, is required. Here medical-aid plays its major role in bringing up an addict to safer condition. Mild Tranquilizers. non-narcotic analgesic and if necessary fluid replacement and Vitamins are administered.

Besides this, the spritual therapy is done. Prayers are done at the worshipping corner already reserved in the De-addiction camp, where all the campers assemble willfully, forgetting their bodypains and emotionally they pray to the "GOD" to help them to get courage to face the pains and troubles of the de-addiction period and make them bold to live in there future-life de-addicted and good-natured citizen. This prayer is done every day in morning and evening in all the three phases. The inmates becomes psychologically prepared to detoxify themselves in any condition but each and every camper is handled carefully and emotionally around the clock specially by those volunteers who de-addicted themselves while attending such camps in past and are well-acquainted with the behavioural tendencies of the inmate under treatment. There are group meetings in nights with painful campers and due consolation is being given by co-friends who were drug dependent in past but are good faithful brothers in present. Thus the myth of death that had a psychosis, in addicts mind disappears automatically and he starts to think in other optimistic way.

Second Phase is of 5th, 6th & 7th day period when an addict of yesterday feels de-addicted and his withdrawal symptoms are reduced to that level that he begins to feel as if he has come out

from the Hell. The 5th day morning-sun rises with the new ray of hope of new life for campers. They all begin to think with an astonishment that a few days back they could not pass a few hours without the drug and had lived for 4 days without it and no harm had been done to them without taking it. Thus they come forward willfully to undergo group therapy and hug therapy which give them mental courage to face the life without drug dependency. In group therapy some topics are discussed, new ideas are cultivated in their minds, fold and devotional songs are sung, recreational activities, indoor and outdoor games, light physical exercises of Yoga are arranged to boost moral and interest for free life of tomorrow. This is the turning point of an addict's life when all types of preventive education, moral strength are infused resulting change in behaviourial attitude and response to advise given to him. Good rich diet with homely affection when given, make physically strong and demand for medical aid is reduced gradually by under treatment addict.

Third Phase is of 8th, 9th and 10th days. These days are the days of new life, the period when a camper feels with pleasure that he has been rescued from the jaws of Death, of the mouth of Hell. He prays to the God and thanks him for the courage he gave to come out from the dark to the light of new hope. For all the campers addiction has become the tale of past days. None believes the magic-change he has got while living as family in the camp and can hardly reach to that point which made them all the detoxified citizen of today, living together in a lonely camp far away from modern poisonous life that attracted them to drug abuse social evil. These

are the days in which they talked freely of their bad habits, accepting wrong act done by every one to each other's family, Society and to the Nation and the courage they got to pass through the life-test to whenever the bad habit. This is the phase when campers sit in front of the God and accept their sins, whole heartedly without any pressure, they had done to their lives and repent for disintegration from society. This is the important period when these campers are made strong mentally and morally to not to fall back to the Drug-abuse, despite the hardened time comes in future life. The behavioural change is made in them for reduce the demand of Drug in future. Not only that become preachers who could work as preventive force in their locality to keep away youngster from Drug abuse.

Tenth day is the last day of the camp. The day of parting away from that camp where campers lived as brothers of a new society. All those who came as broken and weekend persons disintegrated from their families and society, hatered by many, darkened future with little hope of detoxification, made transformation of their life (कायाकल्प) by their own courage, are ready to go back to the real happy life they lost under Drug dependency. They are leaving camp for entering into their homes, sweet homes where their parents are awaiting their arrival as a changed child, to whom they would offer their affection, love, regard and blessings, where they would be the embassador of our De-addiction campaign done at Manaklao or at mobile-camps arranged by the Opium De-addiction Treatment, Training & Research Trust.

Achievements

Since 1979, when the author of this paper took this mission as the Social service, 720 Drug deaddiction camps have been arranged and approximately 60,000 persons have been de-addicted.

It was the 21st camp when Ministry of Welfare gave recognisation to our work and sent a team of Higher officers in which the then Joint Secretary was the incharge, who perused the working of camp and its result; and a pilot camp, which was our 22nd camp, was arranged with Ministry's financial aid, at Delhi in Kanjhawala village, in which young boys of Heroin addicts were detoxified and thus with combined efforts of Ministry of Welfare more camps have been organized in Rural areas of Rajasthan, in 1986 we have organsed big camp at Bangalore city. The table noted below will enable you to know our camping places.

The economical condition shows that those who earn less than US$ 30 per month are very high in addict percentage. More is the income lesser is the rate of Drug addiction. Similarly the age group is also very fearful, Young boys and girls are high in Drug dependency in cities and in village old are opium addict.

Table No. – 1

Income Group Per Month	Percentage
Less than US$ 30 p.m.	44.47%
More than US$ 30 to 50 p.m.	29.79%
More than US$ 50 to 100 p.m.	18.34%
More than US$ 100 p.m.	7.40%

Table No. – 2

AGE GROUP IN CITIES

Participant's Age	Percentage
15 Years	40%
16 to 24 Years	25%
25 to 34 Years	18%
34 to 44 Years	10%
45 & above	7%

Table No. – 3

AGE GROUP IN RURAL AREAS

Participant's Age	Percentage
15 Years	5%
16 to 24 Years	10%
25 to 44 Years	20%
45 to 54 Years	30%
55 & above	35%

Thus campers stand as an example of reoriented life, who would motivate others addicts brothers & sisters to live this drug-abuse habit while attending the de-addiction camps, where they lived and magic change they got by their own efforts, courage and will-power. Thus new horizon comes for them and our camp organizational cycle goes on to save the present Society.

In this manner, giving free service, food, medicine, medical aid and preventive education to the addicts our trust is detoxifying addicts achieving result of 70% to 90% for opium addicts and 50% to 60% for Heroin Ganja etc. Drug-dependents. The followup is done by postal survey and keeping touch with selected de-addicted persons who are called for volunteer help in camp arranged time to time.

CONCLUSION

The country -- the whole UNIVERSE is in danger of this social evil. To prevent and eradicate this menace the Opium De-addiction Treatment, Training and Research Trust, manaklao is devoted to the sacred cause and is proving a source of inspiration.

The innovative approach and detoxification of addicts conducted at Manaklao De-addiction Centre and in Mobile Camps has changed the Social situation – particularly in Rajasthan tremendously.

To sum up the status of our organization, it can conveniently be said that MANAKLAO MAGIC : Yes the very name consumewr the healing almost magical touch of our team even on hard-core addicts, which is evident from the large number of addicts coming of their own in every camp. Yeoman Services are rendered to the cause of de-addiction, which has been recognized on national and international fare.

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EVALUATING RECOVERY SERVICES: THE CALIFORNIA DRUG AND ALCOHOL TREATMENT ASSESSMENT (CALDATA)

Executive Summary

Submitted to

State of California
Department of Alcohol and Drug Programs

by

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at the University of Chicago
and
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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
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August, 1994

Dear Colleagues:

Twenty-two years ago I was administering the drug treatment program in Vietnam. We did not know what worked then. Now we do! The recent California Outcome Study brought the most rigorous science ever applied to our treatment system and documented that treatment and recovery programs are a good investment.

In California, we have assumed that alcohol and other drug abuse treatment works. We have viewed it as an investment and not a cost. Recognizing the significant return on investment, economically, and in terms of social and individual opportunity, we asked the next question: Does treatment work well enough to justify the use of scarce public funds to help pay for it?

Governor Pete Wilson has taken this question very seriously. As Governor, he invested more than $2 million in this landmark study of the effectiveness and benefits of alcohol and other drug abuse treatment. This monograph summarizes the most rigorous, retrospective outcome study ever conducted on drug abuse treatment. This scientific investigation documents the success of treatment and recovery.

In 1992, there were approximately 150,000 persons in treatment in California. A rigorous probability sample of 1900 were included in this study with follow-up covering as much as two years of treatment. This sample was drawn from all four major treatment modalities including therapeutic communities, social model, outpatient drug free and methadone maintenance.

Results indicate three major points. First, treatment is very cost beneficial to taxpayers. The cost benefit averages $7 return for every dollar invested. Second, criminal activities significantly declined after treatment. In 1992, the cost of treating approximately 150,000 individuals was $200 million. The benefits received during treatment and in the first year afterwards totaled approximately $1.5 billion in savings. The largest savings were due to reductions in crime. Finally, significant improvements in health and corresponding reductions in hospitalizations were found during and after treatment. Emergency room admissions, for example, were reduced by one-third following treatment.

The next phase of our research will focus on extending these projections to cover lifetime benefits, and better recognizing cost-beneficial forms of treatment. This California study corroborates a number of smaller studies in the United States which prove that appropriate alcohol and other drug abuse treatment works. Treatment is a good investment!

Sincerely,

ANDREW M. MECCA, Dr.P.H.
Director

PURPOSE

Under the leadership of Governor Pete Wilson, the California Department of Alcohol and Drug Programs (CADP) launched an initiative, in 1992, to determine the epidemiology of substance abuse and the outcomes of substance abuse treatment. The California Drug and Alcohol Treatment Assessment (CALDATA) is the first product of this initiative. CALDATA is a pioneering large-scale study of the effectiveness, benefits, and costs of alcohol and drug treatment in California, using state data bases, provider records, and follow-up interviews with participants in treatment. CALDATA's primary source of information is a voluntary survey of publicly supported participants. CALDATA is the first follow-up interview study to use random sampling techniques with this population.

The purpose of CALDATA was to study:

- the effects of treatment on participant behavior;
- the costs of treatment; and
- the economic value of treatment to society.

The **effects of treatment** are the differences in behavior and experience reported by respondents before and after treatment. The **costs of treatment** were calculated from financial records collected directly from the providers involved in CALDATA. These cost figures have been verified for consistency with other data about these programs and are quite consistent with other study results on treatment costs. The **economic value of treatment** was based largely on the costs avoided due to reductions in the burden of crime and illness, as well as a careful review of shifts in income sources.

The California Department of Alcohol and Drug Programs in partnership with the National Opinion Research Center (NORC) at the University of Chicago and Lewin-VHI, Inc., conducted the study during the period of September, 1992 through March, 1994.

METHODS

Phase One

CALDATA gathered information in two phases. The first phase involved sampling counties, providers, and participants in four types of treatment programs in California. The treatment types include:

- Residential programs
- Residential "social model" programs in particular
- Outpatient programs
- Outpatient methadone

Participants were selected at random from discharge (or in-treatment) lists developed on site at cooperating providers. Sixteen counties, 97 providers, and approximately 3,000 participants who were in treatment or were discharged between October 1, 1991 and

September 30, 1992 were selected into the study sample. The random sample was specifically designed to represent the nearly 150,000 participants in treatment.

The number of programs involved in CALDATA is larger than any prior treatment follow-up study. Further, these programs were systematically selected with known probabilities from a rigorously developed sampling framework, so that those individuals followed up are representative of all participants in treatment in the selected modalities throughout California.

As authorized by federal and state law and permitted by consent obtained routinely on admission to treatment, the program records of participants selected for the follow-up sample were read and abstracted to determine additional important research information and to verify the self-reported data[1]. Using a combination of methods including letters, postcards, telephone calls, visits to last known addresses, contacting relatives or institutional connections, and searching various accessible public records, CALDATA staff sought to locate members of the sample and seek their participation in the study.

In order to protect the privacy of respondents, strict confidentiality was maintained throughout the data collection period. The methods used to protect confidentiality were approved by the California Health and Welfare Protection of Human Subjects Committee.

Phase Two

In the second phase, more than 1,850 individuals drawn from 83 cooperating providers were successfully contacted and interviewed in 9 months. The participant follow-up interview was developed for CALDATA based on extensive work with previous research studies. The questionnaire took approximately one hour and fifteen minutes to administer on average. Follow-up interviews occurred an average of 15 months after treatment, with the longest interval being 24 months. Part of the sample was comprised of individuals who were in continuing methadone maintenance treatment, since this type of treatment is typically longer term than other services.

The results of this study will fill many of the gaps in the research literature--such as the detailed coverage of social model programs and the side-by-side comparison of cost and effectiveness of treatment for alcohol, cocaine, and heroin abuse.

The major goal of the study was to provide CADP a thorough analysis of the data on which data-driven policy decisions can be made. Public policy based on fact ensures the best return on investment for taxpayers.

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[1]Studies of the reliability and validity of responses to surveys by drug abusers show that addicts provide generally truthful and accurate information (Hubbard, R.L., et .al., 1989, *Drug Abuse Treatment: A National Study of Effectiveness*, Chapel Hill: The University of North Carolina Press, p. 31).

KEY FINDINGS

THE COSTS-BENEFITS OF TREATMENT IN CALIFORNIA

Taxpaying Citizens

- *Costs and benefits to taxpaying citizens*[2]: The cost of treating approximately 150,000 participants represented by the CALDATA study sample in 1992 was $209 million, while the benefits received during treatment and in the first year afterwards were worth approximately $1.5 billion in savings to taxpaying citizens, due mostly to reductions in crime.

- *Daily trade-off*: Each day of treatment paid for itself (the benefits to taxpaying citizens equaled or exceeded the costs) on the day it was received, primarily through an avoidance of crime.

- *Cost-benefit ratios for taxpaying citizens*: The benefits of alcohol and other drug treatment outweighed the costs of treatment by ratios from 4:1 to greater than 12:1 depending on the type of treatment.

- *Differences by treatment types*: The cost-benefit ratio for taxpaying citizens was highest for discharged methadone participants, lowest—but still clearly economically favorable—for participants in residential programs, including social model recovery houses.

Total Society: Economic Benefits

- *Cost-benefit ratios for the total society*: Findings differed when cost-benefit ratios for the total society were calculated. The cost-benefit ratios ranged from 2:1 to more than 4:1 for all treatment types, except methadone treatment episodes ending in discharge. For methadone episodes ending in discharge, there were net losses—mainly from earnings losses to the treatment participants themselves.

Benefits Projection

- *Benefits projection*: Benefits after treatment persisted through the second year of follow-up for the limited number of participants followed for as long as two years. This suggests that projected cumulative lifetime benefits of treatment will be substantially higher than the shorter-term figures. An additional phase of follow-up interviews and analyses would permit a more valid projection of lifetime treatment costs and benefits.

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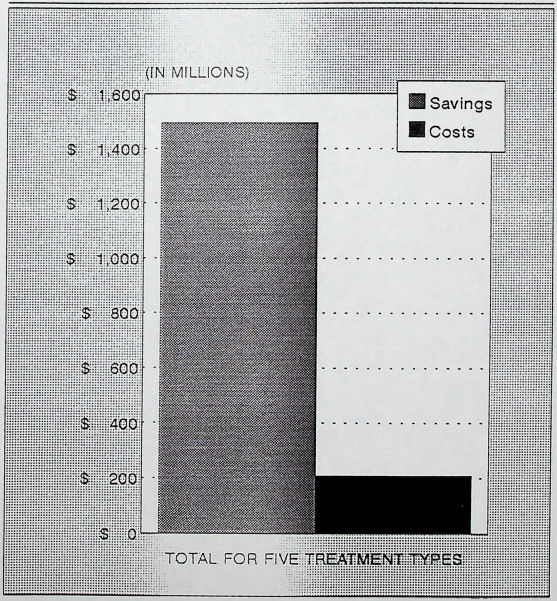
[2]The economic benefits of treatment were calculated two ways: benefits to *taxpaying citizens* and benefits to the *total society*. The major difference is that taxpaying citizens benefit when there is less theft and other crime and when the State makes fewer drug-related disability payments and other welfare-type transfers. However, these transfers of income and property are considered economically neutral to the total society, since one person's loss equals another's gain.

TOTAL SAVINGS AND COSTS OF TREATMENT SYSTEM FOR TAX-PAYING CITIZENS



TREATMENT EFFECTIVENESS

- *Crime*: The level of criminal activity declined by two-thirds from before treatment to after treatment. The greater the length of time spent in treatment, the greater the percent reduction in criminal activity.

- *Alcohol/Drug Use:* Declines of approximately two-fifths also occurred in the use of alcohol and other drugs from before treatment to after treatment.

- *Health Care:* About one-third reductions in hospitalizations were reported from before treatment to after treatment. There were corresponding significant improvements in other health indicators.

- *Differences by substance*: There has been concern that stimulants, and crack cocaine especially, might be much more resistant to treatment than more familiar drugs such as alcohol or heroin. However, treatment for problems with the major stimulant drugs (crack cocaine, powdered cocaine, and methamphetamine), which were all in widespread use, was found to be just as effective as treatment for alcohol problems, and somewhat more effective than treatment for heroin problems.

- *No gender, age, or ethnic differences*: For each type of treatment studied, there were slight or no differences in effectiveness between men and women, younger and older participants, or among African-Americans, Hispanics, and Whites.

- *Ethnic differences in selecting treatments*: There were ethnic differences in the selection of treatment types and in reported main drugs of use. Hispanics were disproportionately in methadone programs for heroin addiction and African-Americans were disproportionately in residential programs (primarily for alcohol and cocaine) compared with non-Hispanic Whites and with African-Americans in other types of treatment.

- *Employment and economic situation*: Overall, treatment did not have a positive effect on the economic situation of the participants during the study period. However, the data indicate that longer lengths of stay in treatment have a positive effect on employment. This finding is greater for those in social model or other residential programs than for the other treatment types. The largest gains in employment occur with those individuals staying in treatment beyond the first month.

- *Disability and Medi-Cal*: In every type of treatment there were greater levels of enrollment and payments received from disability and Medi-Cal after treatment; these increases ranged from one-sixth to one-half. The study analyses indicated that treatment increased the eligibility to receive disability payments and led to overall improvements in health status.

THE HABIT OF
EXCUSE

"I pray thee, hold me excused . . ."

The habit of excuse is as old as the human race. It had its beginnings with the beginning of the human race. It began with the first man and the first woman—with Adam and Eve. And ever since that time history is filled with people who in order to justify themselves, in order to escape from responsibility, in order to minimize their guilt and/or in order to salve their conscience, *excused* themselves.

Let us take a look at the sequence of the events that brought about the first excuse ever used.

According to the scriptures, Adam and Eve were created by Almighty God and placed in the garden of Eden. They were given everything therein for their pleasure and happiness with but one exception. They were told not to eat of the fruit of the tree of the knowledge of good and evil which grew in the center of their paradise. And they were also told that if they did eat it they would die.

Then along came the serpent. He asked Eve how it was that she did not eat of the fruit of the tree. And Eve told him that the reason was that God had forbidden them to do so and if they did eat of it they would die.

But the crafty serpent countered with: "You will not die. God knows that in what day soever you shall eat thereof, your eyes shall be opened and you shall be as gods knowing good and evil."

Then Eve doubted God, believed the serpent, and ate the fruit.

And immediately realizing the evil she had done, she in turn offered the fruit to Adam and he (like so many husbands down through the ages!) in order to please his wife, also ate of the fruit.

And then both Adam and Eve began to be afraid. And when God asked them why they had eaten the fruit, *seeking to escape full responsibility for their actions,* they began to make excuses.

Adam excused himself and endeavored to put the blame and responsibility upon Eve, "The woman you gave me as my companion, gave it to me."

But Eve too tried to escape responsibility and she in turn put the blame upon the serpent, "The serpent deceived me, and I did eat."

And thus began the use of excuses *to justify oneself, to escape*

from responsibility, to minimize one's guilt, and/or to salve one's conscience.

A little later in history we have another excellent example of using excuses. It happened in Adam's immediate family.

Cain and Abel were sons of Adam. They both, the scriptures tell us, offered sacrifices to Almighty God. And we are told that God accepted Abel's sacrifice, but did not accept Cain's. So Cain in his resentment and anger, killed Abel.

Then the Lord called to Cain and said, "Where is thy brother Abel?" And Cain replied with that classical oft-repeated endeavor at excuse, "Am I my brother's keeper?" in order to quiet the fear within and to minimize his own guilt.

Centuries later, the Lord Himself gives three more vivid examples of excuses in His parable about the man who gave a great supper and who invited many of his friends to partake of it. Here's the story:

"A certain man gave a great supper, and he invited many. And he sent his servants at supper time to tell those invited to come, for everything is now ready. *And they all with one accord began to make excuse.*"

"The first said to him, 'I have bought a farm, and I must go out and see it I pray thee hold me excused.' And another said, 'I have bought five yoke of oxen, and I am on my way to try them; I pray thee hold me excused." And another said 'I have married a wife, and therefore I cannot come."

And in all of these instances, they *excused* themselves seeking to *justify themselves, to escape responsibility, to minimize their guilt and/or to 'salve' their consciences.*

The alternative in all of the above instances? There is only one alternative to all excuses and that is the *truth* or as a very common current expression tells us *'let's face it.'*

And what would Adam and Eve have said in place of excusing themselves? Just the simple *truth* which would have been: "I did wrong Lord, I disobeyed your law, I am sorry." And you know something? I don't think the good God would have punished Adam and Eve nearly so severely had they done just that: given an *honest* reply, the *truth* instead of attempting to excuse themselves.

And Cain? It would have been just as simple, "In a fiit of anger, I killed him Lord, please forgive me." And I don't think Cain's punishment would have been as great either.

And the three who were invited to the supper? That would have been simple too, "We don't want to come to your supper."

If this had been done in all the above instances, from Adam on down, they would not have endeavored to justify *themselves* but would have let the truth seek the justification of God which always is *mercy.* Whereas an excuse is but a lie cleaverly cloaked in a semblance of truth endeavoring to deceive another but usually only ending in self-deception. It's root is in *fear,* usually fear of reprisal or punishment. Its primal stirrings are echoed in the words of the small child, "Mommy, *I couldn't help it!"* instead of "I'm sorry, mommy, the next time I shall be more careful."

And thus in the alcoholic we find this age old habit of excuse very accentuated to the extent that every alcoholic is a past master at giving and manufacturing excuses from the initial, "I fell asleep" to the ultimate "I ain't been in the gutter yet." Remember?

And in the alcoholic personalities we find two causes of this over-accentuated characteristic; fear and sincerity.

Most alcoholics are very sincere by nature and in a frantic endeavor to avoid insincerity in facing their human failings, they, more than the average individual, rely on an excuse *to justify their actions, to escape from responsibility, to minimize their own guilt, so 'salve' their consciences.*

Coupled with this circumstance within, every alcoholic is goaded on in many of his actions by an *abnormal fear element* operative in either his consciousness or sub-consciousness.[1]

Thus fear leads one to attempt escape and over-sincerity leads one to self-justification. He (so he thinks) *has* to escape; and also he (so he thinks) *has* to have justification for his actions. And thus, (so he thinks) he retains his *security* and his *character* but in doing so he *really* only retains the shell of both which ultimately completely deteriorate in his alcoholic excesses. And the more he lies, the more he has to lie to justify his lies—and so the cycle goes on and on until

[1] Cf. *Alcoholism: Sin or Disease* published by the *Catholic Information Society,* 214 W. 31st St., New York, N.Y.—10¢ per copy.

at his 'level' he fails to find another excuse and he comes face to face with reality and truth in the ultimate dilemma of every alcoholic: *insanity* or *death* or *total sobriety*.

The habit of using excuses comes from a habit of rationalization, and an excuse may be defined as "an attempt to find a reason, where ther is none," in order to avoid *facing the whole truth*.

This fact is excellently brought out in the story about the Pharisee who asked Christ, "Who is my neighbor"? He wasn't really looking for a true definition of his neighbor, but he was endeavoring to find some definition which *would enable him with smug conscience to omit some of his obligations to his neighbor*. That is the reason the scriptures preface his question with "Seeking *to justify himself*."

The same rationalizing takes place wherever you find a gathering of AAs discussing 'ad nauseam,' "What is an alcoholic"? In such a gathering you can usually be certain that one or more of the gathering is *looking for an out*: "Seeking to *justify* himself"; seeking to justify *another drink*. He is looking for a reason which would permit him without qualms to disassociate from AA and to drink again. But there *isn't any such reason*, so he queries on and on "What is an alcoholic?" hoping sometime to find an ingredient given by someone *which doesn't apply to him*, and which he can use then as an *excuse* for drinking again, and thus he *justifies himself, he minimizes his guilt, he escapes responsibility for doing it* (until the 'Brooklyn boys' appear on the scene!) and *he 'salves' his conscience*. The little child again, "Mommy, I couldn't help it."

Now, since the habit of excuses is a basic human fault, let us analyze a few of the more commonly used ones and endeavor to find out their fallacy.

1.. *"Everybody else does it."*—One of the most common excuses used to justify almost any behavior no matter how wrong in itself. The more people we can adduce who do something which we are trying to justify in ourselves, the more is our own guilt minimized—so we think. And in the thinking we *do* 'salve' our own conscience, don't we? But *do* we change the basic law we are breaking? Now really *do we?* Or rather doesn't it remain the same even if *everybody* acts contrary to it?

2. *"They all say . . . ."*—Here we have coming to the rescue of the excuser that old familiar "they"—did you ever meet "they"? Quite a

fiction, not? But when an excuse is needed "they" are so easily quoted; and exactly as *we* wish them to be, in order to justify ourselves, and it *does* 'salve' our conscience, doesn't it? The only difficulty is "they" did not *make* the law we are breaking, did "they"?

3. *"Men of importance (or position, or distinction) do thus and thus."* A very common excuse of the modern era. "Men of distinction" do it so we simply *must* too, and since "men of distinction" do it, it simply *must* be *right*. Or must it? To commercialize on this common excuse of human nature, a certain liquor firm used to portray "men of distinction" who used their brand. At one time they used for a long time the same man as model in their advertising. Then he appeared no more. But the writer met the gentleman a short time later—in a sanitarium on the west coast—coming off a binge, in a ward of drunks! —where there no longer seemed to be much "distinction."

What "men of distinction" do or say does not point to what is right, or good, or best—but gosh, it does 'salve" our own conscience somewhat doesn't it?

4. *"My mother told me so."*—Poor mom! She's gone now, and what a lovely one to blame for our short-comings! She can no longer dispute it. And it is a wonderful 'trump' excuse excellent of use on the spur of the moment when we can't seem to find another. And it will shift the blame; it will enable us (so we think) to escape responsibility: and it certainly will 'salve' the ole conscience quite a bit.

5. *"Every bucket must stand on its own bottom"*—A trite little phrase. And one that is commonly and widely used to excuse from innumerable obligations of charity. When we are too stingy, or too lazy, or too bitter to extend a helping hand to our neighbor, this excuse is a wonderful one to dish out. Or when a twelfth-step call is to be avoided for the same reasons of stinginess, or laziness, or bitterness, just come up with "ever bucket must stand on its own bottom" and after all, let the guy or the gal have a little 'cold' treatment and furthermore one doesn't want to 'pamper' one, does one? And ecce, our conscience is quiet! Shades of Cain! "Am I my brother's keeper"? But you know, bub, it's a funny thing about this law of charity and brotherly love, *you are!*

6. *"Well, after all, one doesn't HAVE to do this or that— to stay sober, or to accomplish this or that or the other thing."* A long one, but an old-stand-by so often used by our 'first-step Johns and Jills' and our 'twelfth-step busy-guys and gals' and the 'meeting every-now-and-

then gents.' Since everything in AA, including the twelve steps, is only suggested, this excuse is a fine one to permit one to omit almost anything not strictly of obligation with a clear conscience. How often do we not hear this excuse in the spiritual life: one doesn't *have* to pray every day one doesn't *have* to go to the Sacraments frequently; one doesn't *have* to meditate regularly—and on and on. No, one doesn't, but one does gotta die, doesn't one? And then? You take it from there.

7. *"I don't (didn't) have the time"*—This is perhaps the most widely used excuse there is and also probably the biggest lies frequently told. Listen to the guy or gal just back from their vacation: "I would have loved to write you, but I just didn't have time"! Listen to the fellow or girl reneging from helping with a church, or AA or social affair: "I would love to help, but I just don't have the time"! And listen to the AA slipping out of a twelfth step call: "I would love to make it, but I just can't find the time right now"! Such really mean they don't *want* to *take* the time, but using the verb *have* in place of *take* does justify them, nor does it disquiet their conscience either.

8. *"I don't FEEL well"*—The obligations that are sidestepped by this, one of the most common of excuses! Duty beckons, but gosh I just don't feel well, *so* I can thus omit the duty, justify myself, and 'salve' the conscience!

There is a story told about a certain young man who went to his boss and asked if he might go home for the rest of the day, because as he expressed it "I just don't feel well." To which his boss very aptly and with much wisdom replied: "My boy, there is one thing you can never learn too soon nor remember too well, and that is this: *most of the work in this old world of ours is done each day by people who just don't feel well.*"

They also tell the story about a certain member of AA who had promised to lead a meeting at a neighboring group. However, on the day he was to do so, he called the secretary of the group and begged to be excused because he had laryngitis and the doctor told him he should not speak over a few minutes at a time. It was forty minutes later when he hung up the phone after talking that length of time to the secretary!

9. *"At least I'm not a hypocrite"*—A wonderful conscience-salver used profusedly by alcoholics and even on occasion by many others. "I don't go to church, but 'at least I'm not a hypocrite about it'—I admit it"! "Sure I drink—even too much on occasion, but 'at least I'm not a hypocrite about it' and I could stop any time I choose"! "Yes, I know I should do something about my faults, but 'at least I'm not a hypocrite about it'—I admit I have them"! So not being a hypocrite excuses from anything that I have a sneaking suspicion I *can't* or *don't want to* do anything about. And lo and behold there is peace within my conscience. Is there really, chum?

10. *"I'm not a saint"*—A very potent excuse for any fault, wrongdoing or sin that I may not want to or be able to correct. And the funny thing about this excuse, it has more of truth than the usual mine-run ones. There can be no doubt about it—I'm *not* a saint. But you know something? Do you know what the Lord is going to say when we use that one with Him? He is going to simply query back, *"Why?"* "With all of My helps, and opportunities given you of grace and strength and direction, why?" Then, what will the answer be? Huh? . . . but for the nonce it is a lovely excuse isn't it?

11. *"You gotta let go once in a while."*—And to this rationalization is often appended as verification, "and my doctor, or the psychiatrist said so." So thus I can indulge in anything good, bad or indifferent and my conscience is at rest, for after all, "You gotta let go." And strange as it seems, one hears the same advice when one comes to AA but it is a bit different in its content. It contains the whole truth—*"Let go"*—but *"Let God"* direct the extent of it. Remember? Let go —*let God?* And then, strange as it may seem to some too, we no longer *need* excuses if we *let go*—and *let God! For God is truth!*

12. *"I know a fellow (gal) and he (she) is a WONDERFUL CHARACTER who does this, or that or the other thing. . . ."*—It is amazing how many very ordinary people become *wonderful characters, wonderful* AAs or *wonderful church members* when we want to use them as an excuse! D'jever hear it? "I know a fellow, and he is a wonderful AA and he doesn't go to meetings very often, or he doesn't do much twelfth step work, or he doesn't go for this prayer and meditation stuff, etc. etc. etc." . . . ad infinitum. And having identified ourselves with this imaginative *'wonderful* fellow' our conscience is easily lulled and we stand justified—so we think!

13. *"If I don't, he will."*—The favorite excuse for the one in business. The fact that one's competitor does this, that or the other shady business certainly does not change the basic moral law for us, but it certainly does provide a wonderful excuse for our breaking it because after all, "If I don't, he will" and so we are justified . . . are we, really?

14. *"It's a woman's privilege."*—The ladies would like it much better if we left this one out, but then this is no time to be using an excuse, is it? And the one thing we could never find out about this almost universally used excuse about a woman's privilege, is who gave them the privilege? But gosh, it surely does excuse almost every eccentricity of womanhood, and justifies their every aberration, and gives them a blissful conscience, doesn't it?

15. *"I'm a little 'wacky'"*—Why some people would rather be considered a "little wacky" than a sinner is incomprehensible, but the fact is that many would. But do you know the real reason behind such 'screwy thinking'? Being a 'little wacky' excuses one from doing anything very seriously about all the faults and failings and sins. And it does soothe the conscience and blind one from the real truth. The real truth? If one is a sinner, he has an obligation of changing, hasn't he?

16. *"But, you see, I'm different."*—Different from what? But that matters very little, just so we are different from others—and who isn't pray tell? "But to my mind if I am different (no matter how little or hazy that difference may be) I must then have *different* obligations, and since everybody else accepts most basic human obligations I must, since I am 'different,' be freed therefrom—especially those obligations I do not want to live up to." And so our conscience is 'salved' and we are justified in our misdeeds—well, at least in our own mind. Peace—it's wonderful!

17. *"I have changed"*—and of course since "I have 'changed' one would hardly hold me to anything I may have promised, or planned, or agreed to before 'I changed,' now would they? And, by 'changing' I have set aside rather easily, if not so truthfully, quite a number of old responsibilities. And then too, one would hardly be expected to have to live up to a promise made so long ago. And now I can go merrily along without the slightest pang or twinge of conscience and I do feel so justified."

18. *"Times change."*—This old stand-by takes several forms and is first cousin to the one above. "You gotta be modern" or "you gotta keep up with the times" express the same theme and are but two of its many dresses. And since the modern crowd does this or that, one simply must "keep up with the times." But we wonder what would happen to this excuse when placed side by side with the time-proven truth: "Times indeed do change a lot; but souls change very little; and God not at all." Gotcha thinking, hasn't it?

19. *"Well, I am always very frank and outspoken."*—And with that trump up my sleeve we may say what we please no matter whom it hurts or how much it may sting to the very depths the heart and soul of one of whom or about whom we are 'so frankly' speaking. Gosh, what an out: No effort needed now to 'hold back' this or that unkind remark—just be frank! And so we are justified in omitting all that tedious discipline necessary so often to keep back the uncharitable dagger—which the Scriptures themselves tell us is the most difficult of disciplines. But you know something? The Scriptures also states that "he who thinks himself to be religious not bridling his tongue, that man's religion is "vain." And "vain," brother means "worthless" in the English language.

20. *"You see, I'm the nervous type."*—And thus tantrum after tantrum; explosion after explosion: and fault after fault will go uncensored—for after all since "I'm the nervous type—it's nerves." Faults? Of course not, it's nerves! And that label so nicely fits any and all aberrations I don't want to overcome—listen: "I wasn't angry, I was only nervous"! "I don't 'blow-up' at him, it was my nerves"!; "I'm not lazy, just resting my nerves"!; "I'm not jealous, she just simply makes me nervous"!; and on and on and on—by the way, who's kidding whom?

21. *"AA comes first."*—and thus, my friend, we are exempted from many, many obligations—to wife, home, work, and what have you. The excuse that has produced so many 'AA widows' throughout the ranks of AA. And believe me, it is amazing how many otherwise honest fellows and gals blissfully side-step obligations of every sort with a smug: "AA comes first." It's number 3 on the hit parade.!

We could devote much space to a discussion of this one of the most common excuses in AA, but suffice it to repeat what we have written in the Silver Book of Attitudes, namely: AA does come first, *but* that means, chum, the twelve steps in one's daily living, not necessarily the *Twelfth Step* with all of its activities.

22. *"No dues, no fees, no money needed in AA so why should I give to this, or to that..."*—And here comes the one in the number 2 spot on the hit parade of AA excuses. But a wonderful one to use for soothing the ole conscience when one wants to avoid giving to any AA project—from the weekly 'kitty' to the special 'kitty,' the Club, the banquet, and every request for financial donations. And to the above rationalization some subtly add: "And furthermore you can't buy and sell sobriety."

Since this excuse is one of the very "fine-line" ones, perhaps a little story might throw the light of exposure on it.

One time a preacher was urging all of his listeners to 'be saved.' And in flight of oratory he told them again and again: "And the salvation of the Lord costs us nothing; it is absolutely free."

After he had finished speaking, one of the audience approached him and queried: "Say, preacher, you talk and talk and you say that salvation is free, that it costs us nothing. And then how is it that every time you preach you pass the collection basket?"

To this the preacher replied with an answer that is a classic: "Yassah, I did and I do say that salvation is free, that it costs you nothing just like the water that the good Lord has given us—it costs absolutely nothing, *but* when it comes to the 'piping,' we gotta pay for it!"

23. *"I'm an alcoholic"*—Lo, the number 1 excuse in AA. And with this trump card up one's sleeve almost any aberration can be easily excused, and our conscience will feel peaceful, and our responsibility practically nullified. For what can one expect? *I'm an alcoholic!"*

We get angry—but what can you expect? We're alcoholics!

We are lazy—but what can you expect? We're alcoholics!

We are dishonest—we lie—but what can you expect? We're alcoholics!

We chisel and cheat, we nurse every fault we ever had—but what can you expect? We're alcoholics!

And on and on—but you know what? It won't be long until such will have to add an adjective to that excuse; or perhaps just another line: "We're alcoholics, and we're drinking again!"

But after all what *did you expect?*

Really, let's face it, aside from the compulsion to drink, there isn't any difference between the alcoholic and the rest of men. Remember the saying: "If you can't smell 'em, you can't tell 'em"?

THE TWELVE STEPS AND EXCUSES

But the lives of all are *loaded with excuses* which is but another way of saying that poor human nature is frantically endeavoring to justify itself and its actions, is trying to escape from responsibility, is trying again and again to minimize its guilt and is attempting at every turn to 'salve' its conscience so that it may somehow or other live *in peace with itself.*

Books and books could be written and much space given to little else but a listing of the thousands upon thousands of excuses that human beings have and do use. However such is not within the scope of this booklet, and the above is merely a cross-sampling of the excuses that you and I, that all of us are familiar with. And as alcoholics we were past masters at the art of excuse making.

When we came to AA and were confronted with the twelve steps again we were faced with a 'big' order to handle. And again we with hangover of habit or designedly used excuses in taking these steps; so that many members along the twelve steps' path have so rationalized and excused that they have never *fully* and *honestly* taken the twelve steps *literally.* Why? It is the old story: we want to escape responsibility, we want to minimize our guilt, we want to justify ourselves in our omissions, and we want to thus 'salve' our consciences. Because we as alcoholics must have serenity even though it be *'frantic'* serenity.

Now let us go over the twelve steps quickly—merely listing *one* excuse as a sampling of the hundreds that many come up with to 'get around' each step.

I—*We admitted we were powerless over alcohol and that our lives had become unmanageable.*

Because of the necessity of admitting, perhaps for the first time in our lives, an absolute truth: *that we are powerless* and because of the humility necessary to make such an admission, the alcoholic is adept at finding hundreds of excuses that will enable him 'in good conscience' and with 'self-justification' to avoid taking this step in a hundred percent fashion. And among all of these rationalizations, perhaps the most common is that one that has been used for years and years. "But I'm not *that* bad." "Yes, I get drunk, I get into trouble, etc. etc. but *powerless?* O no, *I'm not that bad"!*

Some months ago the writer had a long-distance call from a party

who was interested in helping a certain individual who had had difficulty with his drinking. His problem had become such that for many months he had not been able to work. And somewhere along the way someone had given him the writer's name whom he had been told might be able to get him work.

When the one with the problem himself came to the phone, he was asked whether he had had any contact with Alcoholics Anonymous. But to this 'insult' he quickly replied in typical excusing fashion: "O, but I'm not *that bad!*"

To which came back just as quickly: "Then why in the world aren't you working?"

He now is a very active and sober member of AA and has an excellent position in which he is making a fine record.

However, there are many alcoholics who are not so easily exposed in their excuse-making and who thus come forward with many an added one to 'justify themselves'—in their drinking.

II—*We came to believe that a Power greater than ourselves could restore us to sanity.*

It is amazing and amusing to hear the many excuses that the fellows and gals produce in 'wholesale' fashion to get around this step —this 'God-business.' Let us examine the one most frequently expressed. It excellently fits the present materialistic era. Listen:

"Yea, I could possibly go for this God stuff, but after all *you gotta be practical.*" So, in case you do not realize it, that excuses from all spiritual obligations, and in the excusing justifies one, escapes any responsibility for so doing and lullabies to sleep that wee small voice which most mortals call conscience.

It may not be out place to mention at this juncture an observation on this second step which we feel is often over-looked, but which also often evokes excuses, and sometimes very amusing ones.

We say in the latter part of the second step that we could be "restored to sanity." Now it is the writer's opinion that we cannot be *restored* to anything unless we have been away from it. Therefore in this part of step II we are admitting that we *have been insane.* Else how could we be *"restored to sanity?"*

And, of course, if we have been 'insane' or are 'neurotic' there are

many other obligations that come along which will necessitate the sincere person working at changing these 'personality patterns' which so often—*whether we admit it or not*—got and still gets us into trouble.

And here again—to justify our eccentricities and neurotic tangents of character—we are very expert at producing an excuse. Here's a rather amusing one heard at an AA meeting some years back:

The discussion had drifted into the question that is often 'kicked around' at AA gatherings, namely, "Are all alcoholics neurotic"? Pros and cons were given by the members—'pros' by the honest ones 'cons' by the rationalizers. Then from the back of the meeting room came the pay-off. Suddenly in the middle of a lull in the discussion came this apt observation—a very patent excuse: "I object," this member answered to the remark that all alcoholics *are* neurotic, "Neurotics is nuts, and I ain't nuts."!

"I beg you hold me excused!"

III—*We made a decision to turn our will and our lives over to the care of God* as we understood Him.

Much has already been written on this step and the difficulties in taking it in our Blue Book of Happiness. But there is one excuse used in side-stepping it that is a most common one, and which is very frequently used by human nature in escaping responsibility of all sorts and in justifying all of our procrastinations. And that excuse is just one little word: "Manana"—which translated means "to-morrow" and which Augustine so aptly calls the "corvina" or "raven" of work, duty, and virtue. "Tomorrow"—"yessir, I'm going to take the third step—*to-morrow*" But, you know—there happens only and always to be just *to-day.* For we can never do anything to-morrow—not until tomorrow becomes *to-day*—and if we are always going to take the step *to-morrow*—that means in plain language—*never!* But it does make us seem to have *good will,* and *good intentions,* (but incidentally not many *good actions*) and that justifies us, and 'salves' our conscience and permits us to escape without too much disturbance many, many responsibilities.

And thus always and everywhere: "I beg you hold me excused *to-day*—because I'm going to do it *to-morrow*"!

Whom *are* you kidding?—besides *yourself!*

IV—*We made a searching and fearless moral inventory of ourselves.*

A job and a big one. And a rather 'nasty' one too—very unpleasant. So we need a good excuse here—and a very common one is taken from the Scriptures—that gives it authority. "A searching and fearless moral inventory? Why, I just don't believe in such things for the Scriptures say: 'Let the dead bury the dead,' and again, 'Let sleeping dogs lie,' and furthermore it 'disturbs my peace of mind' "!

And having what we think is scriptural backing, our conscience is in fine mettle, we are justified, and escape much guilt and responsibility of restitution.

By the way, where is it also written: "Woe be to them who cry peace, peace, where there is no peace' "?

'Frantic' serenity!

V—*We admitted to God, to ourselves and to another human being the exact nature of our wrongs.*

In this step we very often find used another excuse that justifies procrastination in order ultimately to side-step or omit all or part of the humbling experience intended by the 5th step. And again, under the mantle of truth, an axiom of AA is adduced in the role of an excuse. "Easy does it"—so why make oneself go to another human being? "Easy does it"—so why take a chance in revealing my misdeeds to another one? "Easy does it"—there's plenty of time to take this step. And lo and behold "Easy does it" gets an entirely new meaning, which translated means: "Keep putting it off, chum—that's the *easiest* way out of it"!

VI—*We were entirely ready to have God remove these defects of character.*

"Who, me? Why, I'm too bad for that. You just don't know what I have done. I've done too many wrongs for God to forgive and to change me." An excuse stemming from 'big-shot-itis' in reverse. It is positive that we're not the best guys now, so why not be the worst? And then, too, that excuses us from doing anything about all of our past. And it justifies us in retaining all of our defects of character, and soothes our conscience, and we are freed from all responsibility.

It seems like one of God's greatest attributes has disappeared—

His mercy. What is that He tells us: 'the greater the sin, the greater the mercy'?

VII—*Humbly asked Him to remove our shortcomings.*

"Humbly"—which means that it demands humility. And wherever there is a question of practicing humility, the pathologically proud alcoholic immediately seeks escape and becomes the master again in excuse-making. And in the seventh step one of the most common goes something like this: "God knows me, so why should I bother to ask Him to remove my short-comings"? or "Who am I to tell God what to do." Very subtle, very suave and very effective—in justifying one's faults, and in minimizing their guilt.

They tell the story of the old fellow who was asked by his minister why he did not say his prayers. To the query of the minister the old fellow always replied: "Me pray? Why who am I to tell the good Lord how to run his business?"

"I beg you hold me excused"!

VIII—*We made a list of all the people we had harmed and became willing to make amends to them all.*

In this step the most often used excuse consists of only one little word: "*But.*" "Yes, I did a lot of wrong, *but*—it wasn't *all* my fault —*but*—*he* also harmed *me*—*but*—it just couldn't have been helped."

And thus, in blaming others our responsibility is minimized, we 'salve' our consciences and we are justified in omitting many 'harms' from our list.

By the way, who is going to even *those* up?

IX—*We made direct amends wherever possible except when to do so would injure them or others.*

In this step many fail to derive any benefit and excuse themselves from the many valuable acts of humility intended by it by glibly coming forth with, "My priest, (minister, adviser, etc.) said it wasn't necessary." Having gone to such a one who although perhaps thoroughly grounded in theology was not familiar with the basic needs of the alcoholic, these individuals indeed were told that it would be sufficient to make *indirect* amends, and that such would suffice to satisfy justice and rights and restitution. However any solid AA could have told

them in the twelve steps 'something has been added' in this matter of restitution, that *direct* amends is advised because thus and thus alone does the alcoholic acquire true *practice* of humility, which humility the alcoholic needs perhaps more than anything else. But by *indirect* amends we keep our anonymity, don't we? Yea chum, we keep our *pride* too . . . ! And incidentally, we are laying aside a 'leetle' drink for a rainy, blue day!? Indirectly!

X—*We continued to take personal inventory and when wrong promptly admitted it.*

Stepping all around this step but never taking it are all of the many "extroverts" in AA. And with the mental 'ambi-dexterity' of such they proffer a time-worn excuse: "It disturbs my peace of mind." But of course such do not hear the echo that always accompanies such an excuse, and which has been and is sounded down through the ages: "Peace, peace and there is no *peace*,"—except on the surface. So these deluded souls go blissfully on in their frenzied activity with their 'frantic serenity,' and their consciences are 'salved' but never *healed* until the day sooner or later when their 'problems' will 'come busting out all over'—with the help of the bottle. Better continue the process begun in the *fourth* step fella, it is much easier to daily 'dislodge' than to ultimately 'dynamite'—remember? ?

XI—*We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry it out.*

In approaching this step, which, incidentally, could contribute so much to peace of mind, sobriety and serenity, one very frequently sees it side-stepped by the much over-worked excuse: "I ain't no 'Bible-thumper,' I ain't no 'pious-puss,' I don't go for that constant prayer business." And to this is usually added an echo of the excuse used in the seventh step, "and furthermore, God knows what I need, He knows what to do."

How very true, chum, *but* do *you?!*

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

Since this step comprises much on the activity side of the program

with its speaking, twelfth-step calls, meetings, etc. etc., we find hundreds of excuses offered. But again, let's look at only one—a very frequent one: "I wouldn't mind speaking, (or I wouldn't mind making twelfth-step calls, etc.) but I have so many other things to do!" And so, with smug conscience, we enjoy all the blessings of sobriety without having to make an effort to give in return. Shades of the parables! "I bought a farm and must go see it; I have bought five yoke of oxen and must go try them; I married a wife . . . I beg you hold me excused." But you know what? It won't be very long until those old excuses are again slightly changed—"I bought a 'fifth' and must go sample it." Which you *will.*

LET'S FACE IT

"And the TRUTH shall make you free . . ."

As we have tried again and again to point out in previous volumes, the tenth, eleventh and twolfth steps are the *daily* living of the AA program. And if we look a bit closer in our analysis, we shall find that all three have *one aim*—namely, *to learn truth in order to eliminate the habit of excuse*, so that gradually and little by little we can motivate our daily living *with truth* instead of the habit of excuses.

In the *tenth step* we take our *regular* inventory so that we may be able to see ourselves *as we are*—faults, talents and all; *in order to learn the truth about ourselves* and thus eliminate *excuses* about ourselves.

In the *eleventh step* we seek through daily prayer and meditation to *learn the truth about God and ourselves*, and thus knowing the *truth* about our relationship with God, we are able to eliminate the habit of excusing ourselves in our obligations to *God*.

In the *twelfth step* we work with others, with our neighbor. *in order to learn the truth about our neighbor and ourselves* so that thus knowing the true *relationship* between *our neighbor and ourselves* we are able to eliminate the habit of excuse which so often wrongly freed us from so many of our *obligations to our neighbor*.

In these three steps we also find on further analysis that their *core* is *meditation* which is nothing more nor less than *a searching with God for truth in order that we may ultimately motivate our living with truth instead of the habit of excuses*. And so we do not hesitate to offer as our opinion that *without meditation contented sobriety is impossible* and *without contentment, sobriety will not be permanent.* "We *sought* through . . . *meditation.*"

This is probably the most talkative age of history—not only because of the abundance of mechanical devices to diffuse our talking, but also because we have little inside our minds which did not come there from the world outside our minds, so that human communication seems to us a great necessity. There are few listeners, although St. Paul tells us that "faith comes from hearing." *If the bodies of most of us were fed as little as the mind, they would soon starve to death.* Many otherwise good and pious individuals wonder why they make little or no progress in their spiritual life in spite of daily and frequent vocal prayer. The real reason is that *they are spiritually*

mentally starved. They say hundreds of verbal prayers—but they never regularly meditate and as a result they are attempting to live in a *spiritual vacuum*—a metaphysical impossibility. And so there is of necessary hyperactivity, restlessness, talkativeness—and a tremendous over-emphasis on activity and movement. One's soul and body in this contradictory state of affairs is constantly attempting to *rest in motion.* Whence such excuses as "I went out to a party to *relax!*"; or for a drive, or dancing, or on a trip! Someone has said that the rocking-chair is symbolical of this vacuum-starved mentality of the era—it enables one to sit in one place and still be on the go.

Anyone who becomes ill at ease or disquieted when the activities of the day or evening cease and one is alone proves that he or she is living in flight from his or her true self. Gregariousness, the passionate need for a crowd, or the "gang" or the incessant urge to identify oneself with the tempo of the time or the continual "pushing the day into the night" is proof positive that one is seeking distraction from innerself, because innerself is a void, is a vacuum, is *spiritually mentally starved.* As we mentioned above in the beginning: "they attempt forgetfulness by courting the sham fancies of the night and by rushing headlong through the chores of the day"—*even the spiritual chores!*

In their spiritual life, not even having stopped long enough to *know God* in meditation, they again resort to constant activity—prayers, services, novenas—by the dozen. Thus they cover up their true spiritual status which is builded upon activity and not on God's will. They merely *work* for God; they do not *love* Him. They do not want to be on the "outs" with God, as a clerk does not want to be on the "outs" with his boss. And so, with so little love operative in their arid and empty spiritual life, God's law and prayer are regarded as mere correctives, as something negative and restraining to their wishes. They ask of prayer that they keep from serious sin—that they will be enabled to restrain themselves *moderately* in their avarice, in their selfishness, in their intemperances, in their sins of the flesh. Their excuses in pursuing this half-track to God which always ends in wreckage here or hereafter are ridiculous. Listen to a few: "just a "white" lie; just a "little" drink just a "little" petting or "pitching"; God can have this and that *but this and that I shall keep for myself,* and after all I do say a lot of prayers." Like the wife who sets out just what her husband may and may not do and then adds: "And after all I do "yackity-yack" at you so much!"

Such souls have no *real* desire to know what God *wants*—they only

wish to *tell* Him what *they* want Him to do—*so much, no more.* One finds out what God really wants *only in meditation.*

Meditation feeds the mind with *truth* about God, themselves and their neighbor—it breaks down and through the self-deceit and the excuses which so foster the aimless and ceaseless activity of which we have spoken. It puts back again into one's life the only safe guideposts: *His* Laws as He meant them to be, to offset the excusing habit of His laws as *we* want them to be *for us.*

But here again human ingenuity and diabolical rationalization side-step what seems to be such an evident truth and necessity for both peace of soul and salvation—with an excuse. *Any* excuse—just so it will justify more activity, just so it will *excuse* one from *facing the truth* in meditation. A common one: "I'm too busy"—and of course, with the over-activated-mind-starved-triphammer-gregarious-soul there is little doubt but that they are *very busy*—in fact they *are* too busy—*period.* For, if one is *too busy* to meditate regularly, that person is *too busy.*

Little do they realize that logic (of which they have seemingly such paltry knowledge) would point out to them that it is *impossible* not to have enough time to meditate. Rather, it is just the opposite: the *more one meditates the more time one will have.* We don't have enough time for God because we don't think enough of Him in meditation. The time one has for anything or anyone depends on how much one values such. *Thinking determines the use of time; time does not rule our thinking.* So the problems of spirituality, of spiritual reading, of prayer and meditation *is never a matter of time;* it is *a problem of thought.* Silence and thought have made many a saint; *words and talk never have*—it is *possible* to pray *vocally* until life's last hour and still lose one's soul; it is *impossible* to *meditate* regularly and lose ones' soul—for, it does not require much *time* or *activity* to make a saint —it requires only *much love*—and who can *love* a person without *frequently* thinking about them ? ? ?

So let's take a closer look at this meditation business, which seems to prove such stumbling block to so many. Why, we know not, for in reality *meditation is so simple.* Again, it is merely *a thinking about truth in the presence of God in order to motivate our lives with truth instead of the habit of excuses.*

It need not be formal. We personally feel that the less formality the better. We need only to see that there are *three* ingredients:

mentally starved. They say hundreds of verbal prayers—but they never regularly meditate and as a result they are attempting to live in a *spiritual vacuum*—a metaphysical impossibility. And so there is of necessary hyperactivity, restlessness, talkativeness—and a tremendous over-emphasis on activity and movement. One's soul and body in this contradictory state of affairs is constantly attempting to *rest in motion.* Whence such excuses as "I went out to a party to *relax!*"; or for a drive, or dancing, or on a trip! Someone has said that the rocking-chair is symbolical of this vacuum-starved mentality of the era—it enables one to sit in one place and still be on the go.

Anyone who becomes ill at ease or disquieted when the activities of the day or evening cease and one is alone proves that he or she is living in flight from his or her true self. Gregariousness, the passionate need for a crowd, or the "gang" or the incessant urge to identify oneself with the tempo of the time or the continual "pushing the day into the night" is proof positive that one is seeking distraction from innerself, because innerself is a void, is a vacuum, is *spiritually mentally starved.* As we mentioned above in the beginning: "they attempt forgetfulness by courting the sham fancies of the night and by rushing headlong through the chores of the day"—*even the spiritual chores!*

In their spiritual life, not even having stopped long enough to *know God* in meditation, they again resort to constant activity—prayers, services, novenas—by the dozen. Thus they cover up their true spiritual status which is builded upon activity and not on God's will. They merely *work* for God; they do not *love* Him. They do not want to be on the "outs" with God, as a clerk does not want to be on the "outs" with his boss. And so, with so little love operative in their arid and empty spiritual life, God's law and prayer are regarded as mere correctives, as something negative and restraining to their wishes. They ask of prayer that they keep from serious sin—that they will be enabled to restrain themselves *moderately* in their avarice, in their selfishness, in their intemperances, in their sins of the flesh. Their excuses in pursuing this half-track to God which always ends in wreckage here or hereafter are ridiculous. Listen to a few: "just a "white" lie; just a "little" drink just a "little" petting or "pitching"; God can have this and that *but this and that I shall keep for myself,* and after all I do say a lot of prayers." Like the wife who sets out just what her husband may and may not do and then adds: "And after all I do "yackity-yack" at you so much!"

Such souls have no *real* desire to know what God *wants*—they only

wish to *tell* Him what *they* want Him to do—*so much, no more.* One finds out what God really wants *only in meditation.*

Meditation feeds the mind with *truth* about God, themselves and their neighbor—it breaks down and through the self-deceit and the excuses which so foster the aimless and ceaseless activity of which we have spoken. It puts back again into one's life the only safe guideposts: *His* Laws as He meant them to be, to offset the excusing habit of His laws as *we* want them to be *for us.*

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It need not be formal. We personally feel that the less formality the better. We need only to see that there are *three* ingredients:

1) *The presence of God.*
2) *Thinking.*
3) *A decision to apply the truth to our lives.*

It is immaterial *where* we meditate, or *when* we meditate, or *what position we take* when we meditate. We can meditate *anywhere*, because God is *everywhere* especially inside us, so that no matter *where* we may be *God is present.*

We may take any *position* when we meditate. We may sit down, or stand up, or lie down, or walk up and down—or, should it more facilitate the matter for some alcoholics—we may even "stand on our heads" to generate the thinking process! Many may prefer to kneel, but we should bear in mind that all of this makes little difference to God who is not looking at our position but at *our hearts.* Just so we "set and think" instead of only "settin' "!

Likewise, one may meditate morning, noon or night. For this too makes no difference to God, we feel sure. However, it will facilitate the forming of a *habit* of meditation if we set aside a *regular* time each day. It gives our wills something to hang on to. It is good psychology.

What should one meditate about? We should meditate about *truth—any truth.* They may be truths about God, about our neighbor, about ourselves, about objective things—about *anything.* A few examples: death, God, marriage, alcoholism, drunkenness, Christ, the Bible, the universe, the laws of nature, the virtues, the vices and on and on—*any* of the thousands of truths. *All* we need to do is to *examine it in the presence of God; apply it to ourselves and our lives; make a descision to motivate our living by it.*

A good spiritual book will be a great help to many in guiding their thinking—especially in the beginning. *Spiritual reading* provides the *fuel for meditation,* it gives us *food for thought.* And we should never forget that the *more spiritual* our reading is, the *more practical it will become!*

Is there a *method* for our meditations? There are hundreds in the many volumes written about meditation. But here again, let's keep it simple. We are alcoholics, remember? And of all the methods, we feel that there is one that is very simple, very effective, and very easy to use. That we like to call the "Who, which, what" method. And in using it, all we do is to present the truth to be meditated about to our minds and ask the *seven basic questions of analysis*:

Who?
What?
Why?
Where?
By what means?
How?
When?

The answers to these seven questions will give ample analysis of any truth and will provide an excellent and effective meditation. A detailed example will be given later on in the meditation on death, appended to this little booklet.

The secret of every meditation is the *decision,* for action is still the magic word. In other words, when we meditate we should always conclude by thinking to ourselves: *if this or that or the other thing be true—therefore we shall do this or that or the other thing—today.*

Let us never forget that the more we meditate the less we shall excuse oursleves; the less we excuse ourselves the more we shall accept; the more we accept, the less conflict shall we have; and the less conflict we have the more peace of mind; the more serenity we shall acquire. And it is our opinion that *unless a human being meditates of his own free will, the day will come and has come for all of us when God will force us to meditate*—and *that* meditation will not be so pleasant. Remember coming off the last binge?

Therefore if we regularly meditate, we shall never *have* to meditate! So—

LET'S FACE IT!

MOBILIZING THE COMMUNITY TO REDUCE DRUG AND ALCOHOL ABUSE

A Manual for the
Community Health Worker

Contents

PREFACE

Developing a community programme to prevent drug abuse can be a massive exercise involving many organizations or it can be the part-time activity of one person. We hope that this booklet will be useful in both of these contexts. On the whole we are assuming that a primary health care worker will be able to get together with at least two or three others to form a **community action team**, but we realize that this might not be possible in some settings. A community alcohol team (CAT) is made up of representatives from health, the police, business, social services, voluntary bodies, parents, teachers and any other groups or organizations with an interest in preventing drug and alcohol abuse and their related problems. Throughout this booklet we attempt to provide wide ranging advice on how to mobilize a community and it may appear that we are expecting too much. Before we proceed, therefore, it is appropriate that we provide some reassurance. This booklet should be used in any way that seems relevant to your specific situation. An isolated primary health care worker or other interested person might be able to develop one small programme. On the other hand a large and enthusiastic community action team might be able to develop a series of projects. Also a trainer will be able to use it as a teacher's resource. We hope that this booklet will be useful to all three.

Ideally, this booklet should be read in conjunction with other booklets in the series.

Introduction

When individuals, groups or organizations work together it is often noted that the whole can be greater than the sum of the parts. This manual is concerned with the task of mobilising the whole community to take coordinated action directed towards the prevention of drug and alcohol abuse. In a recent innovative programme in Pakistan, for example, village health committees have worked in close liaison with a medical practitioner to develop just such a community response. Village committees consist of influential and enthusiastic people who can make sure that changes occur. They have been given training in the early detection, referral and rehabilitation of drug users in their localities. Also working in close collaboration with school teachers and students they have placed a great deal of emphasis on health education. It is this kind of active liaison between groups or organizations that must be encouraged if the recent worldwide escalation in the problem of alcohol and drug abuse is to be reversed.

1. The Need to Mobilize Communities

The use of psychoactive substances is a phenomenon with which all communities and countries have intimate acquaintance. Some drugs will be illegal but others with abuse potential will have been sanctioned for use in religious rituals, community ceremonies and leisure time activities. Although these socially acceptable drugs are in everyday use they will, almost certainly, result in some harmful consequences.

Whenever a new drug appears on the scene, it becomes a matter of some concern, all the more so if it affects the young, the women, and the economically productive adults or becomes symbolically associated with changes in social norms and values. This concern leads to many kinds of community response which, if properly channelled, can form the basis for a community action programme. It is, however, a much more difficult task to persuade a community that there are good reasons to be

worried about substances which have been traditionally used for ceremonial and recreational use (e.g. tobacco, alcohol, raw opium, cannabis products, khat and coca chewing). The community may have failed to recognize the capacity of these drugs to produce harm, or may have decided simply to accept the costs.

It is sometimes difficult to persuade a community that they should be concerned about cigarettes and alcohol abuse.

Since traditional drugs of abuse are accepted by a society, a change can only be sustained if the community becomes actively involved in promoting good health. What follows is an attempt to provide guidelines for primary health care workers who are ready to be involved in the challenging task of mobilizing a whole community.

2. The Community Action Team

At this stage we must refer the primary health care worker back to the preface of this publication, where we attempt to provide some reassurance. Although we hope that the primary care worker will have a key role to play in nudging a community towards healthier attitudes and lifestyles, there is no doubt that help will be required, right from the start. For example, one of the most difficult but interesting tasks will be to build up a clear picture of the community. This will include some knowledge of the drugs which are used and abused but it includes much more besides, including answers to some of the following questions:

- Which organizations make important decisions?

- Who are the key individuals?
- How are plans and concerns communicated or disseminated?
- How are the price and availability of drugs determined?
- What legislation is involved and how is it enforced?
- Which professional and voluntary workers are interested or could be persuaded to take an interest in drug abuse?
- Which other individuals or groups could help or have some influence?

To facilitate the collection of this type of information, a **community action team (CAT)** should be formed with representatives from health, the police, business, social services, voluntary bodies, parents, teachers and any other groups or organizations with an interest in preventing drug and alcohol abuse and related problems. The first task of this group will be to collect a wide range of background information.

3. Background Information

A complementary publication in this series provides guidelines on how to **assess** drug related problems within a community. Ideally this

should be consulted before attempting to build up a file of useful information.

Evidence and information should be collected and collated on the following topics:

o How is the community organized?

Even within a small area, communities have their similarities and differences. Some village communities have hierarchical structures whereas others are more democratic. There will be differences between rural and urban societies and different types of groups will co-exist within a particular community. There will be various pressure groups, as well as formal and informal associations involved in a wide range of areas such as agricultural development, education, women's concerns, parent-teacher activities and labour unions.

It is important to be able to understand how the individuals and the groups relate to each other and how the community leaders lead, as well as the communication styles that they use. The interactions that would prevail in a hierarchical rural society may be different from those obtaining in the urban areas. Even within a hierarchical rural society, the village headman or tribal chief may have absolute authority in settling certain kinds of issues, e.g. disputes about land, marriages and economic rights, whereas, on other issues such as drug abuse, the authority may be exercised by some other person or group.

A clear picture of the leadership and communication patterns within a community is an invaluable asset to the PHC worker or the community action team. An ability to plug into the correct community communication channels and the ability to influence opinion leaders and decision makers will make a or break a community action programme.

o What are the customary methods of problem solving and decision making?

Communities have their own methods of solving problems and taking decisions about issues of common concern to their members, such as drug abuse. In some rural societies this could involve a discussion of the problem by an informal group or a committee under the leadership of an elected or traditional leader. The decision might then be binding for the rest of the community. In urban societies problems might be discussed

by an elected community welfare group (e.g. The Resident's Welfare Association) or a recognised formal association (e.g. the Employee's Union). The community action team (CAT) will be attempting to negotiate with these key decision making groups in order to get drug abuse issues onto their agenda and effect an appropriate response. This can only be achieved if the **appropriate** groups are being approached in an **acceptable** way.

Changing a community will involve negotiations with key individuals and groups

If the action group is attempting to increase drug education in schools then should they approach the education minister, parent-teacher associations, headmasters or a group advising the minister on the content of the school curriculum? Which groups or individuals have a vested interest in preventing accidents resulting from drug and alcohol abuse? This type of information is as important as information about the prevalence and the nature of drug abuse within a community.

o What are the major drug and alcohol related problems?

In the complementary WHO publication on assessment of drug and alcohol abuse in the community we outline ways of exploring the problems resulting from drug abuse within a particular area. Evidence of local drug-related problems, when clearly and vividly presented, provides a very useful method of encouraging a community to regulate

itself. Evidence such as the following speaks for itself:

- Over 30% of drivers killed in road accidents have high blood alcohol levels. On Saturday nights this figure rises to 70%.

- Over 30% of those requesting help from primary health care workers and social workers are abusing drugs and/or alcohol.

- Drugs and/or alcohol are implicated in 40% of family disputes involving the police.

- Over 90% of people dying from lung cancer are smokers.

Of course, this evidence is not always available for a particular community and evidence from other sources will have to be used.

o What community programmes already exist?

Within the community health service there will be programmes and services that have to cope with drug related illness. It is important to identify these and start up a dialogue with the following aims in mind. First to convince health service managers and clinical teams that drug and alcohol abuse should be given a high priority. Second, to encourage key individuals to participate either in the CAT or in specific programmes. Third, to discuss the possibility that materials, resources and funding be assigned to the CAT.

Of course, the health service is not the only sector which develops health related programmes. Organizations responsible for education, housing, safety, nutrition, policing and leisure might already have an interest in drug and alcohol abuse. If not they could be encouraged to develop an interest. Furthermore, most communities have a number of voluntary organizations which are very active and influential (e.g. Rotarians, youth clubs, study circles and women's groups). When collecting background information about all of these groups and organizations the emphasis should be placed upon two questions, namely: Who are the key decision makers and what makes them tick? If you know what motivates the chief of police then you will know how to present your proposal to him.

o What existing legislation relates to drug abuse ?

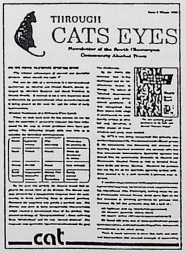
Within most communities there will be longstanding or relatively new legislation relating to substance abuse. In most countries of the world there will be laws derived from the Single Geneva Convention (1961) and the International Psychotropic Convention (1971). Such legislation will have a built-in component to deal with treatment and rehabilitation (e.g. compulsory treatment, legally designated treatment centres, rehabilitation programmes). This information may be available from the police or district health authorities.

The CAT should also be aware of other legislation directed towards tobacco and alcoholic beverages (e.g. health warnings). There may be laws relating to home brewed alcoholic beverages, permitted quantities of alcoholic beverages in individual possession for consumption, age restrictions on the sale and consumption of alcoholic beverages, designated places of consumption, as well as drinking and driving. This information may be available from the alcohol licensing authority or the police.

There will also be existing legislation and penalties that govern the sale and possession of opiates for medicinal uses as well as other psychoactive drugs which have prescription control (e.g. barbiturates, amphetamines, benzodiazipines). The pharmacist, the drug control administration and the district health administrators should be able to provide this type of information.

o How can the CAT get the message to the community?

Most communities will have a local newspaper or news sheet. Many have more than one, as well as other forms of communication (e.g. radio, TV). A very important component of the CAT's work will be to raise the community's level of awareness about drug problems and drug programmes. Again this will involve patiently developing a



strong relationship with key individuals with access to communication channels. Who are the people? Are they interested in health issues? Will they run a campaign? Can they help to develop materials (e.g. leaflets)?

A journalist or a media representative usually turns out to be a very useful and helpful member of the community action team.

4. Developing and Implementing a Community Drug and Alcohol Strategy

Having formed a CAT and collected background information on the extent of drug abuse as well as key groups and decision-makers, the next stage is to use all of this information to develop a few plans. Before moving on to this stage the following basic principles should be borne in mind.

- **Negotiate, don't dictate**: When attempting to change relatively fixed beliefs it is wise to look for areas of agreement or common agendas. For example, if a school or sports club is obsessed with "fitness through exercise" it should not be too difficult to discuss a drug programme within the same framework. The owner of a bar is in business to make a profit. Encouraging the sale of low alcohol beers should help his profits and also reduce drink-driving accidents.

- **Aim for small successes:** Don't worry too much about the daunting prospect of developing a large, comprehensive community drug and alcohol strategy which addresses all drug issues in all age groups within all sectors of the community. Instead go for smaller scale objectives which stand a chance of succeeding. Plan an article in the local newspaper. Persuade a policeman to start a drink-driving campaign. A small success tends to lead to other small successes. Small successes are good for morale. Furthermore, they attract support and sometimes resources and funds. Wherever possible ensure that one key worker has responsibility for a particular project since diffusion of responsibility can lead to confusion and chaos.

The rest of this chapter provides a number of possible interventions

which may or may not be relevant to a particular community. They are provided simply as examples.

o Developing a drug and alcohol information resource

The CAT should be in a position to utilise information derived from the **community assessment**. This data may show, roughly, the numbers of individuals who abuse a given type of substance. It might also indicate some of the adverse health and social consequences, e.g. loss of weight related to a drug habit, repeated chest infections (tobacco, marihuana smoking), drug overdose (suicide and accidental overdose), poisoning (related to methy-alcohol consumption), family discord and violence (alcohol intoxication), loss of family assets (opiate habit), petty crime and theft, (alcohol and opiate habit).

In addition some information might have emerged about existing programmes, including those directed towards treatment, rehabilitation and continuing care. Put all of this information together and the primary health care worker, or other member of the CAT, is in a very good position to serve as an information resource for the community. The CAT might consider publishing a booklet entitled "Dealing with drug abuse in Kandi" or something similar. Sections would cover the extent of the problem, the consequences of drug and alcohol abuse, as well as suggested strategies for groups and organizations (e.g. education, health, police, leisure, etc.).

o Raising awareness

Publicizing and disseminating the booklet on dealing with drug abuse could mark the launch of a programme or a campaign. Discuss such an initiative with a newspaper or your local radio well in advance of the publication so that the dissemination of information is planned and not fortuitous. If you have a wealth of information then you could hold back some of it for future publicity events or newspaper articles. The best strategy is to remind the community about drug abuse at regular intervals but not so frequently that they mentally switch off and the campaign just becomes part of the wallpaper.

Publicity events should be as vivid and as memorable as possible. With the cooperation of a school, arrange for a group of children to dramatically display the number of people who will die prematurely as

a result of alcohol, drug or tobacco use. Ask a local drama group if they could act out a number of brief stories involving the consequences of drug abuse (e.g. drinking and driving, violence within the family). If possible persuade a well known person, or role model, to lead the campaign.

Ask a local drama group to act out alcohol-related violence within the family

Members of the CAT or other interested individuals could be encouraged to address various community groups, e.g., the women's institute, parent-teachers associations, youth clubs.

o Integrating drug abuse interventions with other programmes

Most people are very concerned about their health and well being. When they visit a doctor, primary health worker or pharmacist they are usually ready to listen to advice and this is when health workers should be ready to discuss drug abuse. These workers should routinely ask about drug use and provide advice about changing lifestyles and obtaining further help. Early identification and early intervention is discussed in another booklet in this series but the most important first step is for the primary health care worker to be continuously vigilant. Problems as diverse as depression, nausea and family disputes could well be linked to drug abuse.

The pharmacist is one of the local experts on drugs and will usually be a supportive member of the CAT. Leaflets and advice provided by the pharmacist might be one way in which information can be disseminated.

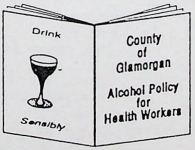
In Zimbabwe (as in many countries) the occupational health nurse is very well placed to identify drug and alcohol problems at an early stage. In one project the nurse has been able to routinely include questions about drug use and especially look out for signs of possible abuse such as Monday morning symptoms, accidents, disputes at work and absenteeism after pay-days. The occupational nurse is then able to follow up early identification with advice and a home visit if this is indicated. If all primary health care workers could follow this model and also obtain help from others then a great deal could be done to prevent the escalation of the drug abuse problem.

o Alcohol and drug policies for organizations

A great deal of drug use occurs within the working environment. Most organizations could be encouraged to develop a policy relating to drug use focused upon health and safety at work. Here are a few examples:

- Wherever alcohol is served on the premises there must also be cheap non-alcoholic beverages so that a choice is offered.
- Employees using complex machinery should not drink or use drugs whilst at work.
- Employees with a poor work record resulting from a drug or alcohol problem will be offered counselling as a first step.
- Smoking will only be allowed in certain designated places since non-smokers have the right to work in a smoke-free atmosphere.

Developing a drug and alcohol policy is an excellent method of raising awareness. It is particularly important that members of the health service provide an example for the rest of the community to follow.



Develop a Youth-Link Network

- A group of young people could be encouraged to develop a "youth link" network of youth groups who are interested in preventing drug and alcohol abuse. Such groups could be linked to the CAT but they would be encouraged to produce ideas and programmes developed by young people for young people.

This youth programme would be one distinct component of the community response and as such it should be managed and monitored by one person, perhaps a teacher, a parent or a young person.

o Law enforcement

The community action team should develop a close relationship with law enforcement agencies since the CAT and the police certainly have common agendas which must be explored. For example in many communities the under-age purchase of alcohol and cigarettes is a major concern. How can the police help to solve this problem? How can the law enforcement agencies influence drug availability? In those districts where community policing is considered to be an effective crime prevention strategy a great deal can be accomplished. For example in some societies it is illegal to serve drinks to people who are already intoxicated and to those who are under age. In one study carried

o Self-help approaches

Fifty years ago in the United States of America two alcoholics concluded that they could not conquer their problem alone but wondered if they could beat it together. Their success lead to the worldwide movement now known as Alcoholics Anonymous. Working on a problem in a group has a number of clear advantages. First, understanding and support is provided by others with a similar problem. Second, those who are coping successfully can pass on helpful advice. Also when attempting to solve a problem two heads are usually better than one. Finally, some people find that they get a great deal of satisfaction from giving help to others.

In Hong Kong the Alumni Association of Sarda is a self help organization composed of and managed by ex-addicts. Following detoxification and rehabilitation former addicts are welcomed back into the community by the group who arrange support and after-care in liaison with health and social services.

A self-help group should be started by three or four enthusiastic people who feel that they would like to get help and give help. They could be drug abusers, recovering drug abusers or members of their families. Self help groups could also provide valuable support to the community action team in a number of ways.

o Developing a youth programme

Drug use is a habit that often begins during adolescence. Perhaps the most effective method of dealing with the drug abuse problem within a community is to prevent the habit developing in the first place. There are a number of ways of educating and influencing young people including the following:

- Education about the harmful effects of drugs should be included within the basic school curriculum, either as a separate course or as an adjunct to other courses (e.g. biology, health care).

- One method of consolidating this teaching is to ask a class to design a set of posters warning about the dangers of drug abuse. A group such as the Rotarians might be persuaded to run a poster competition and present prizes.

5. Monitoring and Assessment

It is important that the CAT obtains as much feedback as possible about developments and achievements since knowledge of results is the only way to ensure that the programme is proceeding in the right direction. If a particular programme is failing then it will have to be modified. On the other hand, knowledge of successes keeps motiviation high and encourages everybody involved to keep up the good work.

When trying to keep track of community action it might be helpful to think of three types of information:

1. **Inputs:** What actions are taken by the CAT? e.g. discuss drug education with the headmaster and the parent-teacher association; persuade Rotarians to be involved.

2. **Processes:** What chain of events follow from these activities? e.g. one teacher volunteered to run a poster campaign, winners' names were published in the newspaper, the Rotarians paid for the printing and distribution of the winning poster.

3. **Outcome:** As a result of all the inputs and processes what objectives are achieved? e.g. is it possible to identify changes in accidents or crime rate, do children know more about drug abuse?

Some of the information needed to monitor the programme can be provided by members of the CAT and the wider group of people involved in the project. Outcome information will also have to be collated from a variety of official sources and if a community survey has been carried out then perhaps it can be repeated.

The CAT should delegate overall responsibility for monitoring to an appropriate person and regular meetings would need to be held in order to keep track of relevant information and feedback.

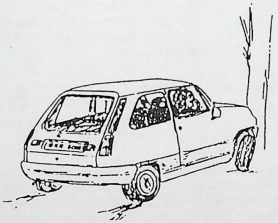
out in the UK a 20% reduction in crime was achieved by a police force who reminded bar staff of these laws and paid regular visits to particular bars to ensure that these laws were being enforced.

The police usually come into contact with drug abusers and their families and could serve as a comminication channel to disseminate information about sources of help and advice.

o Accident prevention

In many societies accidents are a major cause of death in young people and in old age. Because large numbers of young people are involved, accidents are usually near the top of the list of events or illnesses which result in the greatest number of lost years of life. Since drugs or alcohol are usually implicated in more than 30% of accidents on the roads, in the home and at work an accident prevention campaign is an excellent way to start a drug abuse prevention campaign.

Accident prevention will be supported by most communities



One great advantage of such a campaign is that it is usually non-controversial. An accident prevention group could involve brewers, bar staff, the police, public transport and young people as well as health and social services. An accident prevention campaign will be well-received by most community groups and is a good method of developing a nucleus of concerned people. This nucleus could then move into other drug abuse prevention activities. Focusing upon accidents serves as a point of entry into those networks which are involved in decision-making and the process of change.

Final Comments

Drug abuse is a problem that is either stigmatized and considered to be beyond the pale (e.g. heroin abuse) or it is accepted as a leisure and recreational activity (e.g. excessive use of alcohol). Both of these attitudes can persuade a community that no action needs to be taken by them. Furthermore, with alcohol and cigarettes, it is sometimes argued that drug users are free to abuse themselves if they want to. We have suggested that these attitudes should not be confronted directly but that common agendas should be identified (e.g. Is heroin abuse draining health service resources? Are smokers polluting the office environment?). In addition to society's ambivalence about drug abuse there will be many vested interests involved. These should be identified by the CAT.

A community will only have limited energy and resources to direct towards the problem of drug abuse. In order to harness this energy and attract resources the CAT will have to be persuasive and enthusiastic. We have pointed out that *small successes* can generate a great deal of enthusiasm.

Finally it should be noted that members of a community action team should look towards their own use of drugs before they try to influence the community. Changing lifestyles whether they be yours or those of the community is a difficult but rewarding task.

ANNEX I

What are the commonly abused substances?

The classes or groups of psychoactive substances that can be abused and cause problems are diverse. The following are the major classes and general characteristics of such substances:

Depressant substances: This group includes alcohol, the barbiturates, and an enormous variety of synthetic sedatives and sleeping tablets (hypnotics). These substances have in common the ability to cause a degree of drowsiness and sedation or pleasant relaxation, but may also produce "disinhibition" and loss of learned behavioural control as a result of their depressant effect on higher centres of the brain, a property that accounts for the apparent "stimulant" effects of alcohol. These drugs all have the potential to induce changes in the nervous sytem that lead to withdrawal symptoms and the possible seriousness of these withdrawal states needs to be emphasized. Withdrawal from severe physical dependence on alcohol or barbiturates can be life threatening. **"Minor tranquillizers"** of the benzodiazepine type, such as diazepam (Valium) or chlordiazepoxide (Librium), are probably best placed in the general depressant group, although they also have some distinctive features: the benzodiazepines have less potential to induce serious withdrawal states and are generally far safer drugs in clinical practice than the barbiturates, although their dependence potential should be borne in mind. **Alcoholic beverages** are widely used in many societies and because of this their abuse potential is underestimated. Alcohol is a drug and must be used with equal caution.

Opiates (or opioids): The prototype drug for this group is morphine, the major active ingredient in opium. Opium is the resinous exudate of the capsule of the white poppy and contains, as well as morphine, other psychoactive substances that can be extracted in pure form, including codeine, a commonly used drug for relieving pains and coughs.

Morphine can be converted, by a relatively simple chemical process, to heroin. Besides these opium derivatives, there are many entirely synthetic opiates, such as methadone (a drug used widely in the management of heroin abuse), pethidine (meperidine or demerol), and dipipanone. All the opiates share a capacity to relieve pain and produce a pleasant, detached, dreamy euhphoria, and the capacity to induce dependence. Withdrawal from the opiates can be very distressing, but will not be fatal unless the patient is otherwise severely ill or debilitated.

Stimulants: Cocaine is the psychoactive ingredient of the coca leaf. It produces a sense of exhilaration and a decreased sense of fatigue and hunger. Similar effects are produced by a number of synthetic substances, such as the amphetamines and related substances, including phenmetrazine, methylphenidate, and various drugs that have been marketed for the treatment of obesity.

Khat is a shrub, the leaves of which are chewed in the Middle East. The active ingredient is cathinone, which has actions that are similar to those of amphetamine.

Cocaine, the amphetamines, and some of the synthetics can cause extreme excitement and induce short-term psychotic disorders. These substances have a high potential for dependence although the withdrawal symptoms seem to be limited to temporary feelings of fatigue, "let down", and depression.

Millions of people all over the world consume coffee and tea containing caffeine (tea also contains some theobromine). These substances tend to be stimulants in that they alleviate mild degrees of fatigue, but they have a mechanism of action in the body that is quite distinct from that of cocaine and the amphetamines. Generally, they produce very low levels of dependence. Withdrawal, if any, seems limited to some headache and fatigue.

Hallucinogenic drugs: This group includes LSD (lysergic acid diethylamide), mescaline, peyote, and certain other plant-derived or synthetic substances. These substances have the capacity to induce highly complex psychological effects, including transcendental experiences of other-worldliness, hallucinations, and other types of perceptual distortion. Sometimes this experience becomes bizarre and frightening, producing what is commonly

known as a "bad trip". These drugs do not induce physical dependence.

Cannabis: This is the generic name given to the drug-containing plant products of Indian hemp: this plant material offers an extraordinary array of psychoactive chemicals, the most important of which is delta-nine-tetrahydro-cannabinol, or THC. The dried leaves or flowering tops are often referred to as marijuana or ganja, and the resin of the plant is referred to as hashish or "hash". Bhang is a drink made from cannabis. Cannabis appears to have some depressant qualities, but it can also have hallucinogenic effects. Until recently, it was believed that cannabis was innocent of dependence potential but recent evidence throws some doubt on this belief.

Nicotine: This is another drug that merits a separate category. Nicotine can have either a calming or a stimulating effect, or it can have a dual action. Nicotine readily induces a degree of dependence, but withdrawal symptoms are more a matter of restlessness and irritability than acute physiological disturbance.

Volatile Inhalants: These include: anaesthetic gases, glues, lacquers, paint thinners, and so on. There is some doubt as to where to place these substances. They may have some depressant and anaesthetic effects, but they also seem capable of producing perceptual disturbances. The chief danger is their physical toxicity. Solvent sniffing can become a frequently indulged habit, but it is unclear whether in practice any severe degree of physiological or psychological dependence develops.

Miscellaneous Intoxicants: There are a few other drugs that do not fit neatly into any of the drug categories mentioned. Included here are kava, a substance used in some islands of the Pacific, and betel nut, which contains the drug arecoline and is widely used in Asia and the Pacific basin. Still another is the synthetic drug phencyclidine, currently popular among some groups of young people in the USA; in comparatively low doses it causes a mixture of drunkenness and anaesthesia, but in higher doses it causes psychotic states that may resemble schizophrenia.

ANNEX 2

Terms - What do they mean?

A **drug** is a chemical substance of natural, semi-synthetic or synthetic origin which, when consumed, will modify physiological and psychological functions.

A **psychoactive substance** is a chemical entity that is capable of altering mental functions in particular. Nearly all of these substances will cause psychological dependence and some will also cause physical dependence.

Psychological dependence is a condition in which a drug produces a feeling of satisfaction and a psychological drive that calls for periodic or continuous use of drugs to produce pleasure or avoid discomfort.

Physical dependence is a state of physiological adaptation that occurs due to regular intake of a drug, such that it causes severe physical disturbances when the administration of the drug is stopped. These disturbances, called withdrawal or abstinence syndromes are a collection of specific symptoms and signs both of psychological and physical nature that are specific for each drug class.

Hazardous use refers to the occasional, repeated, or persistent pattern of use of a psychoactive substance (or multiple substances) which carries with it a high risk of causing potential damage to the physical and mental health of the individual but which has not yet manifested these ill-effects.

Harmful use refers to the pattern of use which is already causing damage to the individuals health. The damage may be physical (e.g. infections such as hepatitis from self-administration of injected drugs) or psychological (e.g. episodes of depression after cocaine use).

Abuse is a word that is widely used in the field, however, it really is an umbrella term that encompasses hazardous and harmful use.

ANNEX 3

Community Participation Checklist

The following checklist can be consulted when assessing a specific intervention. The ideal programme involves the active participation of the wider community at all stages. It is developed by the community and not imposed upon it.

1. **Planning:** Was the programme developed after discussing the drug problem with community representatives or was it started without discussion?

2. **Priorities:** Were the priorities determined by the people themselves or by a government agency?

3. **Skills training:** Did training involve short local courses followed by regular in-service training or support? Alternatively was the training provided by a remote institution with no follow-up support?

4. **Implementation:** Was the programme implemented by a community action team (CAT) or was it implemented with no community involvement?

5. **Monitoring:** Was the CAT closely involved in the monitoring process?

6. **Ownership:** Is the programme perceived as a local programme developed by and for the locality?

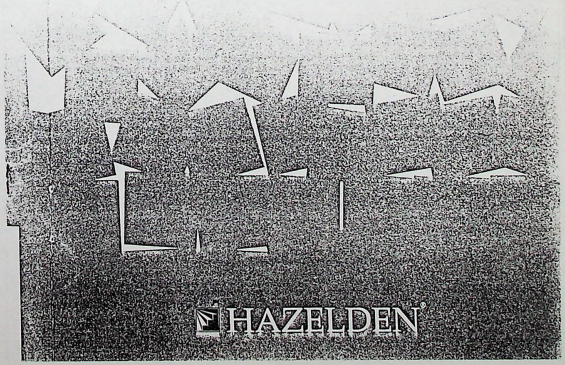
7. **Representativeness:** Does the programme fully involve women, young people, the old and the disabled?

8. **Communication:** Does an infrastructure exist for the exchange of information at the local level?

GRIEF

A Basic Reaction to Alcoholism

Joseph L. Kellermann



HAZELDEN

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by
Joseph L. Kellermann

HAZELDEN®

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Depression or Grief?

"Grief is the real or the imaginary loss of a cherished person or thing. Depression, by contrast, exists despite all evidence to the contrary. The person suffering grief is very much aware of the nature of grief as to its cause or origin. The depressed person is not aware of the cause."

The above definition was given a few years ago by Dr. Hans Lowenbach, of the Duke University Medical Center, now retired. His essential contrast between grief and depression will be followed as well as his descriptions of the symptoms of grief and the suggested steps in recovery.

Depression is completely irrational and may be a psychotic condition. It does not respond to reason, intelligence, or to counseling, but in most cases is self-limiting. It may respond to medication or the treatment of a mental illness through chemotherapy.

Grief, on the other hand, is usually a normal loss reaction, but does not require the loss of a loved one by death. Any basic loss may produce grief, such as the damage to a new car or the loss of a family pet. Retirement and giving up responsibility may produce real grief. Losing a contract or a bid may induce grief. Teen-age lovers frequently experience grief, which is a part of growing up.

Separation or divorce brings grief even though both parties are aware that the action is necessary. Each loses something that was once very dear to them both.

The breaking away of a child as it passes through the period of adolescence may produce grief for a parent. If the parent tries to reach down and pull the child back, the grief increases. The parent must accept the child as a young adult who may or may not turn back to the parent. Pursuing the child in grief only makes it worse. Any family situation which focuses on the lost person or thing, rather than self, increases grief.

Grief is the universal experience of all persons of every race or creed. The only persons who escape grief are those who die before any human love is formed or experienced. Grief is common to all persons and it is included in the Beatitudes: "Blessed are those that mourn, for they shall be comforted." Mourning is working through grief, or the means whereby grief is overcome.

The only persons who are incapable of grief are those unable to experience love and affection with others. The capacity to love entails the experience of grief at some point in life. Husband or wife lose each other in time. Parent and child do the same. The experience of grief indicates the ability to care and relate to other persons. It also entails the ability to enjoy God's gifts to us, things in life which we cherish to the extent we miss them when lost.

Many counselors do not distinguish between depression and grief and treat them as one and the same thing. As the origin of each is entirely different, then working through each is an entirely different process. Unfortunately, in the field of alcoholism, grief is rarely mentioned in the literature and is not considered in most recovery programs for the alcoholic or family members. It is ignored, or even worse, grief-stricken

persons are told that they are depressed, which is considered a form of mental illness.

As grief is a normal condition, medication is not indicated except for one specific purpose. At the time of death, it is permissible for the person who cannot sleep to have medication to get a good night's rest in order to go through the service of the burial of the dead and all that is entailed, which often requires facing an enormous number of persons.

If grief occurs, the grieving person must be permitted to experience grief and helped through grief with the most appropriate means available to the person. Each society and culture has its own process of working through grief, and persons must be permitted to do those things which they have been taught or think are proper in expressing their grief. The same is true in regards to expressions of grief which do not relate to death. The use of medication is an escape from the process of working through grief and postpones a return to a condition of normalcy which cannot occur until grief is resolved. To reduce the pain artificially is not an answer to grief.

Symptoms of Grief

The impact of grief on a person is clearly visible and manifests itself in several ways. The following are observable characteristics:

1. Fatigue and loss of energy are so pronounced that a grief-stricken person may collapse while walking across the floor. Grief drains off energy and the desire to be physically active.

2. Loss of appetite often occurs, although this is not true in all cases. Not eating, of course, adds to the loss of energy.

3. The face may look ten or fifteen years older. The curve of the mouth may turn down as a manifestation of sadness, the opposite of smiling, which often cannot be expressed. The whole countenance of the person takes on an appearance of sadness. This appearance may be only temporary or may last for weeks or months. Working through grief changes the facial expression to the extent that the facial expression is younger.

4. Initially, acute grief comes in waves, and much later on when grief has been overcome, a small wave of grief may appear for a moment. During an initial wave of grief, the person may think that he cannot breathe, and it may be so intense the person may feel he does not want to live. It is like being knocked down by an unexpected wave at the beach and having salt water get into the eyes, mouth, and nose and choke one. Wave after wave is to be expected, but the waves get smaller and the period of calm between the waves becomes longer and longer. In time the calm prevails, but the knowledge of this wave reaction of grief can be of great benefit to the grieving person, by permitting him to know the intensity will last a short while and a less painful condition will follow.

5. Another symptom of the grieving person that is in contrast with the depressed person is that the grieving person focuses on the lost object and can talk about nothing other than the person or thing that has been lost. In alcoholism, this is expressed by the constant focus on drinking and ignoring all other aspects of alcoholism, including any planning or realistic approach to the other problems involved. It does not reduce the grief of the family member (although it may relieve the tension of the moment), but leaves the person with increased emptiness. The constant verbalization about the grief object is a major symptom of grief as it relates to alcoholism.

6. Grief also entails such intense pain that it almost prevents the grieving person from doing anything which adds to pain at that time. This is why the grieving person benefits

enormously by working through grief if alcoholism is the source of grief. Until grief is overcome, it is virtually impossible to take creative action to cope with alcoholism more effectively. To do something which increases the intense pain of grief may seem impossible. Every person has a limit to the pain he can endure and acute grief for the moment is a bit more than most persons can bear if other pain is added at that time. When the grief dies down, the person will be able to consider beneficial action. At that moment, understanding, love, and comfort are needed, not advice.

So grief is the most normal and the most common of all human pains. It is not something that happens to other persons, it happens to all living persons who are capable of caring for others.

Grief of the Alcoholic

The nature of alcoholism produces losses for the alcoholic. There are several forms of alcoholism, but for the great majority of persons, it is a progressive illness which brings on greater losses as the person continues to drink over the years.

1. The first loss is the ability to drink in keeping with the social norm which involves the time, place, with whom, and how much. It also involves the conduct and responsibility of all involved in the social event. The first loss then, is the loss of interest in people and increased interest in the bottle.

2. The loss of memory of drinking experiences, which is alcoholic amnesia, commonly called a blackout. It appears in most in the late twenties, but may appear in the teens or at fifty, sixty, or even seventy in some rare cases. It is the first medical symptom of alcoholism that is clearly visible and occurs when

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As the losses of the alcoholic increase in severity, so does the grief of the spouse of the alcoholic increase, especially that of the wife. Initially she does not attempt to deal with the excessive drinking, because so many persons drink and excessive drinking is, unfortunately, all too acceptable in our culture, which increases the potential for alcoholism. So initial drunkenness does not bring grief in most families.

1. The first real grief appears when the wife attempts to keep the bottle away from the alcoholic, or keep him away from drinking situations or events. It simply does not work. The wife may stop going to social events where drinking is likely to occur, and she loses social contacts with other persons. Vacations cannot be planned in many cases, for drinking begins to disrupt the anticipated happiness of such events. So normal family living and normal social life are lost, which leads to sadness and grief.

2. The next noticeable loss is the loss of order. Life is chaos and confusion. Anything can happen, and usually does, in an alcoholic marriage, so plans cannot be made. The only real order is a state of disorder. This is a loss of responsibility within a home for all parties.

3. Most wives attempt to overcome this irresponsibility by taking over the responsibility as head of the house, and may even go to work to be certain that necessary bills are paid. This is a loss of proper role in marriage, as she becomes sole disciplinarian, dispenser of money and permission to do things, and is attempting to be both father and mother to the child. She also sees her children deprived of what others have in social life and benefits, and this adds to her grief.

4. A fourth loss for the wife may be described as attempts to escape from the reality of the situation. She may become a hermit, or become so active that she does not have time to

feel the losses. Having lost happiness in the home, she may attempt to find it everywhere other than in the family.

A common experience in this stage of adjustment of the family may be called "divorce within the home," which is just as grievous and damaging as separation. This condition may occur only while the alcoholic is drinking, or it may be a prolonged situation, but another tender part of a marriage has now disappeared.

5. Separation is something that happens in most alcoholic marriages, although it may be disguised in many ways. An extended visit with one's parents is a frequent example. Hospitalization for a psychosomatic illness is another. However, separation never occurs as frequently as threats, because the very idea of separation is too painful.

If separation occurs, the alcoholic usually stops drinking and asks that he be permitted to reenter the marriage based on promises not to drink again. Such a request is often granted without requiring that the alcoholic be engaged in a structured recovery program or active in Alcoholics Anonymous.

The wife usually reenters marriage without having become active in her own program to learn how to cope with alcoholism. The idea of divorce is painful and the separation so filled with emotional conflicts, most marriages are resumed after separation with no structured program for either husband or wife.

If reconciliation of the separation occurs without sufficient time and a recovery program for both, the end result is that drinking starts in a short period of time. The result is extreme grief for the wife, who feels that the painful process of separation did not work. She may feel utter despair and that it is a hopeless situation. The separation worked, in a sense, but it was the reconciliation which did not work, because neither was

prepared for it. These are things a spouse should know before taking steps to separate.

Separation should never be undertaken in an effort to make the other party stop drinking. Separation may occur when to remain is so destructive it might take both parties beyond the point of no return. Separation may be undertaken if the sober spouse seeks help, enters a recovery program, and separates on the basis that the alcoholic chose not to enter a recovery program in order to solve the intolerable marriage problems. Separation should not be tried to force the alcoholic to stop drinking, but is justifiable on the grounds that the alcoholic may no longer force the spouse to live in an intolerable situation. In effect it is saying that the wife will not coerce the husband into sobriety, but she can no longer be forced to live under the intolerable drinking situation. It is giving the alcoholic the choice to drink, if this is more important than learning to stay sober and enter into the rebuilding of a marriage, with both parties seeking help in this process. For a wife who enters and remains in her own program, there is a reasonable chance of her working through grief regardless of the choice the alcoholic makes. She also has a real chance of motivating recovery for the alcoholic, with lasting sobriety, true reconciliation, and a good marriage being the possible results. Attempting to put a marriage back together without an alcoholism recovery program brings added grief for both persons.

There are additional losses for the spouse of an alcoholic husband as well as wife. The spouse may begin to suffer psychosomatic illness which interferes with work activities. Wives of drinking alcoholics may fail on the job in the same pattern that the alcoholic misses work. She has sick headaches, makes mistakes, and her absenteeism parallels the husband's stay at home. She may go to the doctor about her anxiety and grief related to alcoholism. Doctors see women in this condition more than they see husbands who are hungover. The wife also loses self-respect and is aware that she is not truthful with her doctor, covers up for her husband with his boss, and never tells the truth about her absenteeism with her own employer. This is the pattern of alcoholism. Grief is a normal reaction to the total aspects of alcoholism and therefore is something that can be understood, and plans can be made for working to overcome it.

Three Steps in Overcoming Grief

There are three basic steps in overcoming grief which may be taken by the grief-stricken person which do not require changing outside circumstances.

1. First one must make a sacrifice. This is true as related to death and other forms of grief. Despite the fact that all seems lost, the beginning of recovery requires the ability to give of one's self in a sacrificial manner. This is the first step out of the emptiness, the utter void of feeling that nothing is left. It is like overcoming paralysis by doing that which seems impossible. It requires faith and courage, but this is the beginning of conscious recovery. For the spouse of the alcoholic, it means giving up the "poor me" syndrome and doing something about the painful condition. It means going to Al-Anon meetings, or to group therapy, or both. It involves the help of other persons who understand and can join in the recovery process.

Essentially, it means an investment of time and energy in a sacrificial manner, in a program specifically designed to meet the needs of the spouse of the alcoholic which will permit her to overcome the sense of loss.

2. Secondly, it means giving up the three questions which begin with "why." "Why did I? Why did he? Why did we?" These questions are asked a million times by the spouse.

Or they can be asked in the negative form, "Why didn't I -- or he -- or we?" It is impossible in life to find an answer to "why" in human conduct, other than all persons exercise choice, and in the process of volition, people do what they want to do, and this is not always right or best for them or others. This is the way life is. There is no valid basis for the pursuit of "why," and in solving a problem, this is the first thing that must be abandoned.

The real problem cannot be faced until "why" is abandoned and one looks at "who, how, when, and where" things happened. Then and only then is it possible to decide what can be done about it from the point of view of changing one's self, one's attitude, and eventually, the reaction to what has happened. We cannot change what has happened. It has happened. It is a fact. We cannot change the historic fact, but we can change ourselves and our response to the fact.

In this aspect, basic religious truth must come into the picture. To ask "why" on a repeated basis is to blame God for letting it happen. If we take a good look at Biblical truth, we learn that God does not let us explain why we did things. We dare not make excuses in approaching God. The author of the Book of Job deals with the question of "why." Job cried out and asked God why all these things happened to him, a godly and upright man. The book deals with the suffering of one who is innocent and does not deserve all these losses. Finally, when Job understood he would be challenging God to continue the protest, he was able to change his whole approach and ask that God teach him. This is when Job began to heal and to be restored. It is the same process for all persons.

"Why" has to be abandoned in overcoming grief as well as in understanding the nature of one's own conduct. "Why" never appears in the creed of any religious faith and is certainly not in any form of confessional. Nor is it found in the Lord's Prayer, Ten Commandments, the Serenity Prayer, nor the Twelve Steps of AA or other similar groups.

If we cannot tell God why we did anything other than it was our own human choice and that we are responsible for what we did, then we cannot demand that others tell us why. To do so would be assuming that we could push God aside and demand that persons answer to us in a way that God will not permit us in our relationship with Him. And like Job, we cannot find fault with God as Job did initially and demand that He tell us why things happened.

So "why, why, why?" has to go, and the focus must be placed on one's own healing.

3. The final step may be termed sanctification, which is the ability to see the lost person or object in an entirely different light. It is a releasing in love that which has been lost. If it is the death of a loved one, it is giving back to God with thanksgiving for the joy and happiness shared with the person before the loss. In alcoholism, it is releasing the alcoholic in love and seeing whatever is good in the alcoholic and being thankful for it without bitterness, anger, hatred, or resentment. It does not mean that one continues to be an unnecessary martyr to alcoholism. Sanctification comes only as a final stage in one's own recovery; it is not the beginning of it.

This ability to see the alcoholic in a new light is a powerful force in the healing process, for it removes the spouse as a provoked female in the merry-go-round aspect of drinking, reaction, response, and drinking again. The reaction of the spouse is now entirely different, so the response must be different. The spouse no longer helps keep the merry-go-round going, and in most cases, this will lead to recovery of the alcoholic as well.

By resolving her own grief, the spouse can now act in freedom, as the intense pain of grief is so reduced it no longer

controls her life. This also has tremendous impact on the grief of the children, who also are freed by her freedom.

Children in a family with alcoholism suffer grief, for they lose not only their security with the alcoholic parent but also lose the other parent to alcoholism by the focus of the sober spouse on the alcoholic. It is not the drinking or drunkenness that cuts the children off, but the fighting and quarreling that does it. Also the children see both parents so involved with each other and the drinking problem that they are left out, and neither parent is seriously concerned with the needs of the children.

A case history will illustrate it. Recently, a forty-two-year-old wife in Al-Anon heard a lecture on grief as it relates to alcoholism, and two days later a program on reconciliation with one's family of origin as the basis of mental health. She put the two together and became aware of the fact that when she was fifteen, she felt that she lost her mother to her father's alcoholism. Later the father died, and she resolved this grief. However, twenty-seven years later there was still a painful relationship with her mother which she recognized as grief which had never been reconciled.

This woman learned she can turn back to her mother, work toward reconciliation with her and overcome the grief. Not only is it her responsibility to do this, but she is aware of the joy she will have in the reconciliation.

Working through grief and achieving sanctification is a problem for children of alcoholics who grow up. There are some who claim that the injury which occurs during the early years of a child's life with an alcoholic parent cannot be removed later on. For adults who still suffer grief from childhood experiences, it is never too late to overcome the grief reaction. Recovery from alcoholism is a lifelong process. For the alcoholic, the spouse, and their children, it does not occur in a thirty-day treatment program for the alcoholic.

How to Help

How does one help a grief-stricken person? There are some things which often prove beneficial and other things which may be avoided.

First and foremost, when a person is suffering from grief, your presence is helpful if you are a loved one and your presence is one of comfort. Most rush in at the first indication of grief and do not go back again when the real problem stretches out over a long period of time. Grief does not disappear quickly. In some cultures and families, when death occurs, other members of the extended family do not let a widow live alone at home for a year or more. A sister, aunt, cousin, or niece is scheduled by family planning to provide residential companionship of a loved one to help the mourning person through the grief period. So the two things you can always give a grieving person are your companionship and your love.

When visiting a grieving person, lend an ear and not a mouth. Do not advise and counsel as did Job's comforters. They tried to tell him why it all happened and nearly drove him out of his mind. Do not try to solve the problem, just be there. Do not try to make him eat, but see that food is available that can be eaten in small quantities. If the grieving person suggests an activity, join him, but do not push or insist that he do what you think he should do. Remaining in familiar surroundings is essential.

Remember also that healing is as much a part of life as sickness or hurt. Time is necessary in healing, but grief should

not be prolonged. Overcoming grief is a spiritual process, and those who wish to participate in spiritual healing need to understand that in spiritual healing, one must be a wounded healer. If a person has not been through real grief, it is impossible to say that "I understand how the grieving person feels." If one has experienced grief, one knows that this need not be said. Your presence and your compassion indicate that you understand the need of the other person and that you really understand how he feels. Your presence conveys the message.

Al-Anon Is Helpful

For the spouse of an alcoholic or for other members of the family, there is one group that is capable of providing the healing process in overcoming grief. By the very nature of its program, Al-Anon provides this, as it is a program of spiritual recovery based on the same Twelve Steps and Traditions of Alcoholics Anonymous. The following are beneficial aspects of Al-Anon as they relate to grief, but there are many other benefits as well.

For the spouse or older children in a family where there is alcoholism, it becomes an extended foster family of caring persons who have been wounded and are healing. The fellowship of this group is one of understanding, and with this group support, the recovery from grief has increased assurance.

Also as the spouse learns to cope with alcoholism and makes basic changes, other members of her own family, especially the alcoholic, initially will often insist that she not rock the boat or that she turn back to where she was. He may even make threats if she does not return to the former position of riding the merry-go-round. If the spouse makes significant changes, she may find herself standing alone with all of the

family, especially the in-laws, turned against her. Having an extended foster family at this time is essential in maintaining the recovery process.

This principle is the same as the fellowship of Alcoholics Anonymous when the alcoholic gives up his/her best friend, the bottle, and cuts off from his/her old drinking buddies, which is a basic part of recovery. Understanding persons are essential for the spouse, male or female, as well as for the alcoholic.

Using the Twelve Steps

The Twelve Steps are wonderfully structured for working through grief, and they are in complete accord with Biblical teaching and faith. First there is the process of surrender of self, which, in effect, is true sacrifice, admitting one is powerless and turning one's life over to the care of God. The other side of this coin is that one does not sit at home and do this. It means going out to the meetings. When God comes to us, he leads us to others with whom we can share our belief in restoration of faith. When we pray, we must put legs on our prayers by getting off our knees and doing something about the prayers we have just uttered. Admitting we are powerless over alcohol gives us the strength to do something about ourselves. At the same time, this is the abandonment of asking why and focusing on how the problem can be resolved.

The Fourth and Fifth Steps, taking one's own inventory and then making a complete confession to God and another human being, is a cleansing of guilt if complete honesty is followed in the inventory and confession. Once this has been accomplished, the loss can no longer be associated in any way as God's punishment for failures of the spouse, either of commission or ommission. It takes away from the spouse the

feeling that drinking is her/his fault or that stopping it is her/his responsibility. Consciously or unconsciously, when the Fourth and Fifth Steps have been completed with honesty, it is impossible to blame God or one's self for the drinking and its consequences. It puts it where it belongs, the responsibility of the drinker, who may continue to drink in a destructive manner or enter a recovery program. It also helps the spouse understand that any statement on the part of the alcoholic as to why drinking occurs is an alibi and cannot be accepted.

In completing the Twelve Steps, the spouse achieves that state of condition which permits sanctification. By releasing the alcoholic in love, one gives back to God and to the alcoholic the responsibility of deciding what to do. It gives the spouse the freedom to remember what is good in the alcoholic and to remember the joy in the life shared with this person as well as the sorrow. This minimizes the loss.

In this process of releasing in love and permitting the alcoholic to choose to drink or seek help in learning to abstain, the spouse is not required to separate or is not required to remain in the marriage. This is the choice of the spouse, who knows not only what is best, but also what is possible for her/him to do at this particular time.

The new freedom of the spouse and the ability to cut the strings which the alcoholic has used to control the spouse as a puppet have profound effect. In a reasonable period of time, most alcoholics seek help and enter their own program. If they do not or will not do this, the spouse at any time may offer the alcoholic reasonable choices as a condition of continuing the marriage or separation. In fact, the spouse may do this to discover if remaining as housekeeper or husband permits the alcoholic to choose not to do anything about the problem.

Finally, it means loving a person enough to permit him/her to fail in dignity without our interference, control,

rescue, or protection. This means that we trust the built-in structure of life itself and its corrective measures, which just might be more successful than those we have practiced in the past. It also means giving up the effort to impose one's will on another person while accepting the responsibility of surrendering one's own to God's will, not to the alcoholic's demands.

Within the family system, healing is as contagious as sickness. When one member of the family seeks help and overcomes grief and remains in that condition of healing without changing back to the old method of dealing with problems, it is predictable that in time others in the family will move toward a recovery also. The real hope of the spouse and children or parents in an alcoholism situation is that of seeking help in overcoming their sense of loss. This, in a sense, is abandoning the alcoholic, but it is done in love. The hope is that this removal of the pampering and protection routine will result in the free choice of the alcoholic to surrender and admit he is powerless over alcohol and enter a recovery program.

If the spouse is the husband and the alcoholic a wife, the needs of the husband and his specific program are even greater. His role as husband is so controlling that unless he is able to overcome his grief and stop asking his wife and God why it all happens, there is little chance of recovery for either partner in the marriage. His healing is the most powerful condition that an alcoholic wife can experience. Few wives fail to respond when a husband overcomes his Pride and his Grief, and humbly seeks help for himself while releasing his wife in love.

A result of overcoming grief is the willingness and effort to share the healing experience with other persons who also suffer grief, especially from alcoholism. The Twelfth Step indicates that the person who has been through a spiritual recovery tries to take this message to others. The message can be extended, understanding and compassion can be offered,

but the witness one bears in the practice of these principles is the means whereby others are able to accept the message and practice it in their lives. Once the healing occurs and there is understanding of how it happened, one is aware of the fact that the main thing worth offering is simply sharing our presence and our love.

As grief is the common experience of all persons and therefore is a normal condition -- not a pathology or sickness -- then recovery is a normal process and falls within the realm of normal spiritual experience. As each of us is able to release in love that person or thing that we have lost, so do we receive the healing power of God's grace. Also as our wounds are healed, so do we become instruments of God's grace in reaching out to others with the message of our recovery and the willingness and need to share this with all others who mourn.

Dr. Hans Lowenbach states that ninety percent of persons thought to be suffering depression are actually experiencing acute grief and deserve the dignity of knowing they are not mentally ill.

This is especially true in the area of alcoholism. The spouse is not a neurotic person who needs a drunk husband or wife, but an average person who is also a victim of alcoholism and experiencing grief, not depression. To know this, to accept it, and to act upon it has tremendous power in solving the problems of alcoholism for the alcoholic and the spouse who initiates the action. Children also benefit by such action on the part of the sober parent.

Today no one needs to remain in grief due to alcoholism. There are counselors who understand and there are thousands of Al-Anon groups capable of assisting the spouse through the steps in overcoming grief.

These steps are simple but profound in effecting a recovery from grief:

1. The willingness to make a sacrifice.

2. Stop asking "why?" which is to imply that God is guilty and we are innocent.

3. Sanctification, that condition which permits remembering that which is good rather than dwelling on that which has been lost.

Everyone has a choice: to remain in grief or to overcome it with the help of those who bear the scars of the same wounds.

Other titles by Joseph Kellermann that will interest you . . .

A.A. - A Family Affair

A fresh look at the importance of the family unit in the recovery process. The author examines the roles of A.A., Al-Anon, and Alateen and suggests that more effort be made to reach whole families rather than just the alcoholic. (12 pp.)
Order No. 1120

Al-Anon: A Message of Hope

The author takes a sensitive look at the demands and expectations placed on the spouse of the alcoholic and details ways that Al-Anon can help. (16 pp.)
Order No. 1135

Alcoholism: A Merry-go-round Named Denial

Thousands of readers have benefited from this analysis of the roles people play in alcoholism: the "enabler," the "victim," and the "provoker." Recovery can begin when the actors stop playing these roles and get off the merry-go-round. (16 pp.)
Order No. 1140

The Family and Alcoholism:
A Move From Pathology to Process

Kellermann describes grief in the alcoholic family, suggesting behavior changes that can help the family and the alcoholic. (20 pp.)
Order No. 1296

A Guide for the Family of the Alcoholic

Weapons used by the alcoholic to control the family and cover up for consequences of problem drinking are destructive and deadly. Here are ways that the family can defend itself. (16 pp.)
Order No. 1300

Reconciliation with God and Family

Recovery for the family includes reconciliation with God and one's family of origin. Find out how family members can initiate a process of reconciliation rather than attempt to change others within the family. (16 pp.)
Order No. 1413

Order No. 1297

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MH - 26.15

Draft for discussion

~~PRESENTATION FOR CONSULTATION~~
COMMUNITY BASED SUBSTANCE ABUSE PREVENTION PROGRAMME WITH A FOCUS ON ALCOHOL

I. Community Based Substance Abuse Prevention aims at helping the community to prevent the abuse of substances. This covers a part of large area which requires behavioural changes of the members of the community. A major point of it, for practical implementation, will be community based rehabilitation of persons involved in substance abuse.

Community based rehabilitation can be defined as a process in which all affected persons of a particular geographical area are helped to develop themselves to their full potential, within their own community, making the best use of local resources and thus. achieve maximum possible integration in to their families/communities.

II. AIM OF THE PROGRAMME

a) The primary aim of the community based substance abuse prevention programme is to shift intervention from the costly, professionalised, specialist institutions to the homes and communities of the persons with disabilities(Francis 1997).

b) By the innovative use of local resources, interventions can be made
more appropriate,
more effective and
more acceptable (Thomas and Thomas 1997).

c) The programme will also be undertaken in the context of the paradigm shift is health from a

Medical model	→a social/community model
Individual	→Community
Patient	→People
Disease	→Health
Providing	→Enabling
Drugs Technology	→Knowledge / Social process
Professional control	→Demystification

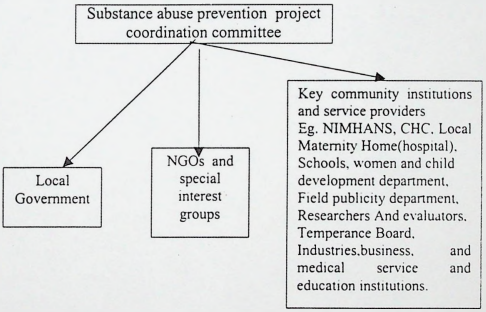
(CHC)

III. PROGRAMME GOALS

- Abstinence from alcohol/drugs
- Change in lifestyle to enhance quality of life.

IV. COMMITTEES

a) PLANNING FRAMEWORK AND PROCESS



b) AT COMMUNITY LEVEL COMMITTEE

Planning, implementation and monitaring community level activities.

Local government Eg. Corporation Municipality Panchayat	NGOs working in the area and other local interest group	Community residents Eg. Women group, Youth group, Men group, and other socio-economic groups	Key community institutions and service providers. Eg. Local hospitals, Schools, Industries, Business, Police, Sponsoring institution

c) **COMMITTEE TO MOBILISE FUNDS FOR PROGRAMME**

1.....
2.....
3.....
4.....
5.....

V. PROGRAMME DURATION

One year
Venue: Programme will be conducted in a school, marriage hall or community centre situated in the areas (slum).

VI. THREE MAIN FACTORS IN COMMUNITY BASED REHABILITATION OF SUBSTANCE ABUSE PERSONS.

The community based treatment programme calls for a coordinated and skillfully orchestrated effort of the programme-undertaking agency, the treatment team and the affected persons and the families in close cooperation with the community.

VII. PROGRAMME TEAM

LINK WORKERS / LOCAL VOLUNTEERS OR ANIMATORS

VIII. ACTIVITIES

Prevention and Promotion	Community based treatment and rehabilitation.	Reducing alcohol availability and use
• Awareness creation for the public. • Poster campaign • Rally • School and college education • Media coverage and advertisement	• Publicity in the area through film shows, pamphlets. posters and different group meetings. • A professional counselors visit to the affected house - to motivate the person. - clarify the programme. - infuse hope about recovery. • Meeting the family members of the affected person to assess problems and elicit their cooperation and enable them to cope with the situation. • Medical screening of the	**Micro level** • Reduction of alcohol problems. • Reduce alcohol availability. • Prevention strategies that target environments where young adults are likely to congregate hold considerable promise for reducing alcohol-related problems. • Prevent illicit – arrack brewing and selling in the slum..

	affected persons with the help of local hospital doctor to rule out major medical problems. • Treatment process (NIMHANS). • Group therapy • Family therapy • Individual counselling • After care activities • Group activities • Recreational activities • Social skills and assertiveness training • Training to the field workers and local NGO staff.	**Macro level (Policy)** • Regulation and taxation of alcoholic beverages • Strategies to reduce alcohol availability. • Increase alcohol price. • Motorcycle helmet. • Motor vehicle safety devices. • New messages and strategies to reach out young adults through media and educational programmes. • Advertisement restriction for alcohol and etc.

IX. **IMPLEMENTING AGENCY, COORDINATING AND SUPPORTING INSTITUTIONS ROLE.**

Local NGO	CHC	NIMHANS
.....	.....	.....
.....	.....	.....

X. **RESEARCH STUDY INTO**

- Extent of problems
- The number of people involved.
- Type of people involved.
- Demographic details.

- Effects of substance abuse on others – family harm and disruption, violence and crime.
- Facilities available for rehabilitation.
- Relative effectiveness of various methods of rehabilitation.
- Evaluation of the programme.
- Number of people available to participate in the programme.
- All legal issues.
- Physical and mental effects of alcohol abuse.

HELPING ALCOHOLICS TO HAVE A SMOOTH RECOVERY

GUIDELINES FOR SUPPORT PEOPLE

HELPING ALCOHOLICS TO HAVE A SMOOTH RECOVERY

- GUIDELINES FOR SUPPORT PEOPLE

Alcoholism is a disease which leads to physical and emotional problems. Alcoholics are people who need support and help to give up alcohol and lead a qualitative life. For an alcoholic, recovery begins with abstaining from alcohol. **This abstinence should be total and for life time.** It should also be followed by the alcoholic learning to manage his life better; **making positive changes in various aspects of his life.**

To help the alcoholic in the recovery process, it is very important that he has well wishers - support people, who are willing to assist him in his recovery.

Support people are those who have a keen interest in the welfare of the patient. They may be the alcoholic's

Family member
eg. Uncle, Sister,
Brother, Father-in-law

Personnel at office
eg. Supervisor, Manager,
Co-worker

Family Doctor

Clergymen

Friend

Support People are those

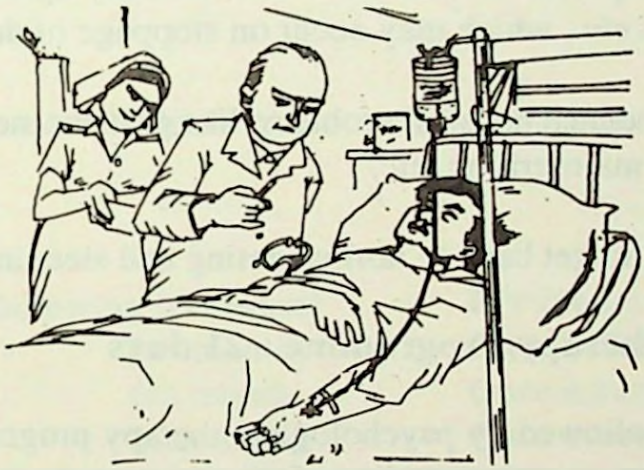
- **who do not use alcohol**
- **who meet the patient frequently**
- **whom the patient respects and holds in high regard.**

The reasons behind having support people are:

- **to give additional help and support to the recovering person**
- **to help in rehabilitating him during his recovery**
- **to help prevent relapses from occurring and**
- **to bring him back for treatment in case he relapses.**

UNDERSTANDING ALCOHOLISM AS A DISEASE

After extensive research, it has been established that **ALCOHOLISM BY ITSELF IS A DISEASE** - a disease which can be treated by giving medical and psychological help.



Without treating this disease, any other alternative like changing the alcoholic's job, getting him married, etc. will not help him stop drinking. Unless the alcoholic **totally stops drinking,** his condition will get worse day by day.

The **disease of alcoholism can be treated.** In the process of treatment, the patient gets help to keep away from alcohol totally for life. Such **total abstinence** is essential and it is the **only solution** to the problem of alcoholism.

GIVING A HELPING HAND

The patient needs medical and psychological treatment to give up alcohol totally and lead a qualitative life.

Medical Treatment (Detoxification - 5 to 7 days) - aims at

- helping the patient overcome withdrawal symptoms such as tremors, fits etc., which may occur on stoppage of drinking.

- treating associated physical problems like gastritis, neuritis, damages due to malnutrition, etc.

- helping him to get back to normal eating and sleeping pattern.

Psychological Therapy Programme - 21 days

Detoxification is followed by psychological therapy programme. The programme provides an understanding of the various aspects of alcoholism and gives an insight into the associated problems. It helps the patient to strengthen his goal of leading a comfortable life without alcohol.

Psychological therapy programme includes

- lectures
- assignments
- group therapy
- relaxation therapy
- individual counselling sessions

CONTINUING TO PROVIDE HELP

Follow-up is a very **important** part of the treatment programme. Follow-up facilities are provided for five years after the primary treatment. **A family member has to accompany the patient during every visit.**

As part of follow-up, medical and psychological help are offered.

Medical care

The patient is asked to meet Doctor / Psychiatrist / Counsellor during follow-up.

Period following treatment			Frequency of visits
1st	-	3rd month	Once in fifteen days
4th	-	6th month	Once a month
7th	-	12th month	Once every two months
After 1 year			Every quarter

The first one year after the primary treatment, is a very crucial period for the patient.

The patient will be on the following medications

1. Disulfiram (Antabuse)
2. Vitamins
3. Other medications, if prescribed.

1. **Disulfiram** is prescribed to help the patient abstain from alcohol. It serves as a deterrent to the alcoholic, because severe adverse reactions are produced if alcohol is consumed after taking Disulfiram. The patient is advised to take Disulfiram (one tablet daily) for a minimum period of one year. Once he crosses the first year without drinking, it paves the way for his future sobriety.

Some cautions to be kept in mind while the patient is on Disulfiram.

a) The patient should not consume even a small amount of alcohol after taking Disulfiram. It produces several unpleasant effects like flushing, sweating, palpitation, shortness of breath, discomfort in the chest, fall of blood pressure, blood vomiting, unconsciousness, etc. It can become life threatening.

b) If the patient has consumed alcohol over Disulfiram, it is an **'Emergency.'** Take the patient to a nearby Hospital. The patient has an emergency card which has to be shown to the doctor.

c) During recovery, even cough syrups or tonics containing alcohol should not be taken by the patient, as this can precipitate a reaction.

d) Even if there is a suspicion that the patient might have taken alcohol, do not give him Disulfiram.

This card gives the list of necessary medications to be administered in this condition. Ensure that this is done immediately to revive the patient. If not attended upon, the patient's life will be in danger.

Sri.....is our Patient and is on Disulfiram Tablet. If you find him unconscious, vomiting and with low B.P., it is probable that the person has taken alcohol when on Disulfiram Tablet against medical advice. Hence, he has to be treated as an Emergency Case and the following treatment should be given

1.	Injection Decadron	- 2	Vials	I.V.
2.	Injection Vit. C.	- 2	Amps	I.V.
3.	Injection Avil	- 1	Amp	I.V.
4.	Injection Glucose	- 5% drip		

Injection, Vit. C. and Decadron can be repeated till the B.P. is restored to normalcy.

Note: Disulfiram tablets are available only at our Hospital. Patients outside Madras city may send a money order to the Counsellor. The tablets will be sent immediately.

2. Vitamins are given for the improvement of general health of the patient.

3. Other medications like anti-depressants, anti-psychotics etc., are prescribed if necessary. These medicines have to be taken by the patient for 3 to 6 months. The patient has to periodically review the dosage with the Doctor / Counsellor.

Even after treatment, patients need counselling. Many issues like problems in the family / workplace have to be dealt with during recovery. Patients need support and strength to face and manage them.

To help them in their recovery process, the following facilities are offered:

1. **Medical help**

   Patients are encouraged to meet the doctor to seek medical advice and report on their progress.

2. **Counselling**

   This helps the patient to face his problems like inability to cope with tension, difficulty in taking up responsibilities etc., and deal with them appropriately. Martial counselling is also provided. Even if there are no problems, the patient is expected to meet the Counsellor with his family member to report about his progress.

3. **Letter writing**

   The patient is asked to write regularly to his Counsellor about his welfare. Counsellors will also periodically write to each patient.

4. **Telephone calls**

   Patient can contact his Counsellor over the telephone.

Apart from these, patients are asked to attend Alcoholics Anonymous meetings regularly. These meetings serve as a further support in their recovery process.

UNDERSTANDING RELAPSE SYMPTOMS

Relapse can and does occur with some alcoholic patients. It is part of the disease of alcoholism. Relapse is a process that creates an uncontrollable craving for alcohol. Prior to drinking, a set of warning signs occur.

Some of the significant warning signs that appear before the patient goes back to drinking are as follows:

The patient

1. Becomes over-confident - ignores follow-up measures. Example: "I can take care of myself." " I don't need the Counsellor's advise."
2. Appears depressed - does not communicate, prefers loneliness.
3. Becomes irritable, angry, argumentative, resentful over minor issues.
4. Indulges in gambling etc.
5. Makes major decisions without adequate thinking.
6. Is unable to eat / sleep properly
7. Stops taking disulfiram tablets and other medicines.
8. Goes with drinking friends
9. Stops meeting Counsellor / going to A.A. meetings
10. Talks about social drinking

If these symptoms are seen repeatedly, the patient has to be persuaded to meet his Counsellor.

Relapse is preventable.

METHODS TO HANDLE RELAPSE

If the patient has started drinking again

Bring him to the Hospital. Guilt feelings are very high during the first few days. Therefore, be supportive and make him understand that with help, he can recover. He needs medical help and counselling.

YOUR ROLE AS A SUPPORT PERSON

You, as a support person have an important role to play in the recovery of the patient. We need your help in the following areas:

1. When no news is received from the patient and his family members, we will contact you to get necessary information.
2. If the patient changes his residence, we request you to intimate his new address to us.
3. If the patient needs a job or wife has to be reconciled, we may seek your help.
4. If the family member finds it difficult to bring the patient back to the Hospital when he has relapsed, we request you to motivate him to take help.

Even if there are no problems, it is important that you keep in touch with the patient regularly and encourage him in every progress he makes during recovery.

A TREATMENT CENTRE FOR ADDICTION

TTK Hospital of TT Ranganathan Clinical Research Foundation is a pioneer, voluntary, non-profit organisation dedicated to the treatment and rehabilitation of people addicted to alcohol and other drugs. The Hospital offers a comprehensive in-patient treatment programme for a period of 4 weeks.

A programme for Support People is conducted on alternate Saturdays between 10-15 a.m. and 11.30 a.m.

For further information - contact:

TT RANGANATHAN CLINICAL RESEARCH FOUNDATION

'TTK HOSPITAL'

17, IV MAIN ROAD, INDIRA NAGAR, MADRAS 600 020

Phone : 418361 / 417528

Working Hours

Monday to Friday	:	10.00 a.m. to 4.00 p.m.
Saturday	:	10.00 a.m. to 12.00 noon
Sunday	:	Holiday

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SELF - ESTEEM

"A BETTER YOU" SERIES - 1

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SELF - ESTEEM

SELF-ESTEEM is essentially a measure of self-worth and importance. When this assessment of oneself is level-headed, reasonable and positive, the person has a strong self-esteem. He then sees himself as a valuable, worthwhile person and feels 'good' about himself. For him, life becomes enjoyable and the future seems to hold a lot of promise. When this self-assessment is a negative one, the person has a weak self-esteem. This individual feels that he is worthless, incompetent and unfortunate. For him, life becomes insipid and the future appears hopeless.

Self-esteem is one's evaluation of himself that colours his perception of events and determines whether he is going to act decisively or give in with a sigh and carry a sense of failure. Self-esteem thus is a very important part of one's personality.

Self-esteem has been shaped from our very early years. During childhood, if an individual's feelings are respected, thoughts valued and abilities recognised, his self-esteem gets strengthened. If, on the other hand, his feelings are trampled upon ('I don't care about what you think/want'), thoughts belittled ('What a lousy idea!) and abilities criticised ('You can never do anything properly'), his

self-esteem remains at a low point of development. Thereafter, depending upon the success or failure in every significant situation in life, coupled with his own reaction to it and the amount of support he receives from others, his self-esteem either grows stronger or gets weakened.

STRONG SELF-ESTEEM

Individuals with a strong self-esteem are able to relate to others in a friendly, understanding manner, build healthy relationships and find themselves successful. They are

- confident
- appreciative
- goal-oriented
- contented

* **Confident**

  An individual with a strong self-esteem knows his strengths and feels secure in accepting his limitations. He is able to place a lot of confidence in himself and in his ability to handle problems. This confidence stands him in good stead through the triumphs and diasters he faces. A crisis does not lead to despair, and triumphs do not lead to over-confidence.

  `Rags to riches' stories and lives of people who have overcome disasters, all have one thing in common - a belief that one can

do it. These success stories are a testimony to what self-confidence can do.

* **Goal-oriented**

His goals are always appropriate and realistic. When he sets his mind on a goal, he is willing to give a lot of himself to achieve it. He readily makes efforts, for he knows that no achievement can be reached without the sweat of the brow. Hard work does not frighten him. On the contrary, it adds excitement to the whole exercise. More important is that he is prepared to own up responsibility for his failures as readily as he does for his successful endeavours.

* **Appreciative**

A person's feelings about others, corresponds to his feelings about himself. The individual who feels happy and 'good' about himself, can make others feel 'good' about themselves too. He is able to readily acknowledge the good in others. He is warm, appreciative and shows a genuine interest in and regard for others. These qualities help him in establishing meaningful relationships.

* **Contented**

This person is able to accept himself with his limitations and weaknesses while clearly being aware of his assets and strengths. He tolerates and accepts imperfections in himself. He is fully aware of his limitations and continues to grow despite their presence. In short, he does not focus on what he does not have and cannot do. He looks into the future and sees what he has and can do.

WEAK SELF-ESTEEM

In contrast, individuals with a weak self-esteem have a negative self-image and a poor self-concept. These hinder their ability to build relationships, to feel comfortable and 'good' about themselves. Weak self-esteem also brings with it other penalties in terms of negative personality traits as detailed below.

Critical

An individual with a weak self-esteem constantly tries to strike out at people. Nothing seems to satisfy his expectations and minor slips are singled out for severe condemnation.

Self-centred

Not willing to consider the feelings and needs of others, his self-centredness alienates him from them. The intensity with which he hangs on to his ideas and needs, inconsiderate of others, only leads to further frustration.

Cynical

Firmly believing that the world is treating him unjustly, this person is ready to believe the worst of others. He carries a huge load of past resentments based on real or imagined injustices done. He misinterprets others' thoughts and actions and makes himself and others miserable.

Diffident

An individual with a weak self-esteem suffers from feelings of self-doubt and insecurity. He looks at even minor failures as proofs of his inadequacy. Even though he may be gifted with abilities, he fails to take up responsibilities and utilise his strengths because he is convinced he will fail.

An individual with a weak self-esteem is, in short, the very antithesis of an individual with a strong self-esteem. A person with a strong self-esteem is all set to enjoy an interesting present and a happy future, whereas the one with a weak self-esteem is heading towards unhappiness and failure.

STRENGTHENING SELF-ESTEEM

A strong self-esteem is thus of crucial importance and the wonderful thing is that it is more NATURAL to us than a weak self-esteem. Self-esteem is a qualilty that can be strengthened at any point in life regardless of age, educational background and social standing. Building up one's self-esteem is a slow process requiring patience and perseverence. Yet it can be done with relative ease, considering that its fruits can be enjoyed for a life-time. We have some basic tips for strengthening self-esteem which are practical and easy to follow.

** **Give positive strokes generously**

Appreciation in the form of words (compliments), facial expression (a smile) or

gestures (a pat) are termed 'positive strokes'. Positive strokes help in strengthening the self-esteem of the recipient as well as the giver.

Giving 'positive strokes' is a healthy exercise which calls for recognition of worth in other people. When we treat others with dignity, respect and love, our own self-esteem automatically grows stronger.

In this mechanical world, we are so caught up with life and living, that we take many things for granted. If we could only pause for a minute and show our appreciation, the world would indeed be a wonderful place to live in.

Murthy sat back and recollected all the pleasant things that had happened over the previous week. "My daughter willingly offered to massage my head, when I had migraine.... my son enthusiastically washed my scooter during the weekend... my colleague volunteered to handle my client when I was pressurised for time. Everyone readily helped without my even making a request." These thoughts made Murthy feel loved, cared-for and 'good' about himself. He would have felt even better if only he had expressed his feelings directly to the people concerned.

We need to put in some effort to recognise the merits of people around us and express our appreciation explicitly. People are well aware of things that go right and feel good about these within themselves. The barrier lies in communicating this positive feeling to the other person. Building up self-esteem calls for breaking this restraint completely. We must be able to comfortably, easily, instinctively appreciate whenever something is done well or better than usual.

While giving a positive stroke

- Look directly into the other's eyes. Looking elsewhere may make the other person feel you don't care or really mean what you say.
- Be specific about what you state. Instead of making generalised statements like, "This shirt is good", be descriptive to make it more meaningful. "This print and the pastel shade suit you", would be better.
- Say it in a clear, warm, tone. A dull, low monotone can convey boredom.

Muthu's son had won a prize at the drawing competition. Muthu took great pride in relating this to all his colleagues the very next day. Surprisingly, he did not say a word of appreciation to his son. The least that Muthu could have done is to have given his son a bright smile and a hug, when he so proudly narrated the good news.

Malathy keeps a beautiful house and is a wonderful cook. Her husband Shekar is proud of her. But in all their 10 years of married life, he has never communicated this to her. All that Shekar needs to have done is to have just looked at Malathy's eyes and told her that he enjoyed eating food prepared by her.

Muthu and Shekar appreciated the other persons deep inside but did not voice their feelings openly.

A positive stroke expressed explicitly and directly, surely helps to strengthen the relationship and build self-esteem.

** **Do not give plastic strokes**

Compliments which are exaggerated or not genuine, can be referred to as 'plastic strokes'. Like counterfeit money, which has no market value, fabricated compliments do nothing to improve the self-esteem of the giver or the receiver. This dishonest underhand exercise is detrimental to the giver as he loses the ability to pay honest compliments. For a while, plastic strokes may be received well. But soon, the receiver becomes aware of this fraudulent exchange and receiving them only makes him feel uncomfortable. Gradually, the 'giver' loses his credibility and his message is discarded, so much so, that even if a positive stroke is presented by him, it is not honoured.

"Balu is a good boy. He always does the jobs I ask him to do.... Come on, Balu! Run over to the corneer shop and get me some sugar" - compliments like these are not genuine and are obviously made to manipulate others to get things done for themselves. These do not benefit either the giver or the receiver.

** **Accept positive strokes with grace**

Culturally, we have been trained to feel uncomfortable while receiving positive strokes. Refusal to accept these valuable strokes, is not a virtue. It is a drawback that discounts our feeling of self-worth and makes sure that our self-esteem stays weak.

Positive strokes are as necessary for maintaining a strong self-esteem, as water is for the plants. Positive strokes ensure emotional well-being. These are invaluable gifts given to us in recognition of our worth. They need to be treated well and

accepted gracefully. Refusal to accept them, is as ludicrous as throwing away a priceless gift. When positive strokes are rejected, it offends the giver and he desists from giving them in future.

> Nita remarked to Rekha, "You are a very efficient person." Rekha's immediate reaction was "You should hear what my mother says!"
>
> Kumar's manager said, "You have done an excellent job of the Brochure". Kumar responded saying, "Well, frankly speaking I am not totally satisfied with the outcome. I feel I could have improved upon the cover page. I am sure the Chairman will not like it".

In the above examples, positive strokes have been examined with suspicion and found wanting. Such an approach prevents us from utilising these positive strokes for our healthy personality development. When positive strokes are given, we need to accept them, relish them and store them carefully to strengthen our self-esteem.

> Rekha could have gracefully accepted Nita's compliment with a smile or a nod, while Kumar could have received the compliment by saying "Thank you for your encouragement, Sir. I am happy that the extra efforts I had put in, have proved valuable."

Even a person with a strong self-esteem, experiences periods of uncertainity. During such moments, sharing one's feelings with someone who is empathetic and compassionate, will help in strengthening his self-esteem.

> Pushpa had been preparing for her examination months in advance. Yet, on the day of the examination, feelings of self-doubt built up. She felt anxious and was afraid she might not do well. After listening to her, her mother

drew Pushpa's attention to the positive aspects. She reminded Pushpa of her consistent good performance in the previous examinations and the hard work she had put into the preparation. Her mother also expressed her conviction that Pushpa would do well. Pushpa felt better on receiving this positive feed back and left for her examination in a confident frame of mind.

During periods of despondency, when everything seems lost, being open about our feelings to a supportive listener, gives us an opportunity to receive positive strokes. These positive strokes remind us of our past triumphs and our potential for further achievements and thereby strengthen our self-esteem.

** **Reject unconditional negative strokes**

Unconditional negative strokes are generalised, all-encompassing, negatively toned statements. Though these statements lack any factual basis, they can cause havoc to the self-esteem of the recipient.

The recipient is often aware that the statement is not fully true. But he ponders over it and asks himself "How could he say it of me?", and wallows in self-pity.

Usha's son said, "You are the worst mother I have ever seen." Usha was aware that this remark was made because he was irritated by her refusal to let him go to a movie. Yet she told herself, "How ungrateful he is! I work so

hard just to make him happy and I get only these words in return."

Praveen was in a hurry and his breakfast was not ready. He told his wife, "You never do anything on time." His wife was upset because she was an efficient lady and usually finished cooking early. She felt that he was being very unfair and unjust and she was deeply hurt.

The penalties for accepting these negative strokes are high. Here, every negative stroke is treated as valid, held as further proof of one's worthlessness and inadequacy, and this perception weakens one's self-esteem.

When an unconditional negative stroke is given, we have the right to reject it. Unconditional negative storkes are garbage which mess up our self-esteem. They make us feel less worthy and we lower ourselves in our estimation.

Self-esteem is of great importance, as our actions, feelings, behaviour and even abilities, and success in life are dependent upon it. By developing a strong self-esteem, we experience happiness, self-confidence and enjoy life. The wonderful thing about self-esteem is that we can change it and improve upon it at any time in life. A strong self-esteem is ours for the asking with a little effort.

Work at the following four steps and enjoy a brighter, happier life.

- Compliment people directly and explicitly and experience that warm feeling within yourself.

  Shun flattery.

- Receive genuine compliments with confidence and grace.

- Ignore unconditional negative strokes, and stay balanced, secure and comfortable.

Now you are letting yourself in for something marvellous - **A BETTER YOU** in short.

EXERCISES TO STRENGTHEN YOUR SELF-ESTEEM

1. Building up self-esteem means being aware of one's own positive qualities.

   If your family members and colleagues were asked to describe you, what words do you think they would use to describe you? (Only the positive ones, ofcourse!). Think for a while and list five adjectives.

   Taking stock of your positive qualities in this manner, helps you to see yourself as a 'worthy' person.

2. Choose one significant person among your close family members. Think of two qualities in that person which you appreciate. Set a time limit to express it directly to that person.

   Malini felt that her mother-in-law

   - had always been supportive in moments of crises
   - took great interest in the up-bringing of her grandchildren, enthusiastically narrating value-based stories daily.
   - took genuine interest in preparing new dishes.

Even as she was recollecting, she realised that she had never expressed her genuine appreciation directly to her mother-in-law. "Her birthday is just a week away. I will use that as an opportunity to tell her this," she thought.

Like Malini, identify qualities that you have liked in the family member you have chosen. Remember, when you are going to express it directly to him/her, say it clearly, be specific about the quality you appreciate and while doing so, look directly into his/her eyes.

3. Maintain a `positive strokes' diary. When compliments are given, record them. Record also the positive feelings you experienced while receiving them - proud, happy, comfortable, thrilled, honoured. During those moments when you are feeling 'low', flipping through this diary will help.

4. List the false accuasations that people made about you in the past. How did you feel? If you did feel hurt, how did you handle it? What are the steps you have planned to take to protect your self-esteem in future?

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MH-26.20

ALCOHOLISM MEETING AT NIMHANS ON 18TH JUNE(Tuesday) 2001

The sharing session facilitated by CHC in collaboration with NIMHANS, was well attended by members particularly from *REDS, APSA, APD, Nava Jeevan Mahila Pragati Kendra and FRLHT. Dr. Latha Jagannathan from the Rotary TTK Blood Bank and Ms. Padmasini Asuri from CHC were also present. NIMHANS was represented by Dr. Mohan Isaac, Dr.Pratima Murthy and Dr. Vivek Benegal and CHC by S.D. Rajendran and Arjun Krishnan. The meeting commenced with Mr. Rajendran telling us all why he had requested this meeting. Each time he visited some of the slums on a particular assignment, the women residents would invariably approach him with one request – "Do something about the alcohol problem in our community". Mr. Rajendran said that even though many of us had been addressing this growing problem for some time now, an effective solution was yet eluding us. It is a big challenge but together strategies could be evolved. He requested the group to share their views and experiences and together attempt at initiating a novel and effective action plan to address the issue. He read out the main issues to be addressed. These were:

- Strategies focused on women to cope with husband's / family member's alcohol addiction.
- Ways to reduce alcohol consumption in the affected areas
- How to instruct the community to support and address this problem
- How to maintain sobriety of people after treatment
- Finally come up with ideas which could seek the eradication of this problem.

He then requested Dr. Mohan Isaac to chair the meeting.

Dr. Isaac spoke of how NIMHANS had been addressing this problem for many years and had not confined their initiatives to the Hospital grounds alone but had ventured into areas where society was facing this problem. He asked each one of us to introduce ourselves to each other and then share our views on what Mr. Rajendran had shared.

Sr Elise Mary of Nava Jeevan Mahila Pragati Kendra, Dr. Isaac felt, could begin as she was directly involved with women's groups who were facing this problem. Sr. Mary spoke of a successful campaign she had recently helped in Tamilnadu. She felt that women need to be united and that was where the success of a campaign or project lay. For instance, in one case the women of a village in Tamilnadu had come together, viewed the problem and taken action by enforcing the closure of a liquor shop in their area. They had the support of the District Collector, without which, she felt the project may not have succeeded. In Karnataka, she said, the women were afraid. Scared of something; possibly their husbands and other men folk. The police were ineffective or reluctant to come forward to help and they too were a deterrent. Here, Mr. Joe Paul of REDS, said that it was not the women in Karnataka who were in question, since most of the migrant population in the slums comprised also of Tamil women. It was probably motivation which was more important. He said that their groups programmes focused mainly on women and children and they had noticed that when they involved this group in some activity or initiative, the men folk were always curious to join in. They came forward to see and ask questions. He felt that women and children were ideal entry points to approach the entire community.

* Names of participants are given on the last page of this report.

Ms. Kamakshy of APD, said that their groups were working with the poor and focused on disability. However the problem of alcohol was often encountered. She said that nowadays due to awareness and empowerment programmes, the women in these areas were now taking on responsibilities and were earning to help support their families. This left the men with freer time and no alternate activity. Probably this freedom with nothing to do and boredom were responsible for them to start drinking. What was needed was a family oriented programme offering alternate ways of recreation / relaxation that could be sustained. She also felt that this initiative should be taken up just like the anti tobacco one.

Dr. Vivek Benegal was of the view that most of the programmes sought only to marginalize the men with an alcohol problem They were singled out and this led only to denial and an attitude of defensiveness among them. It would be more appropnate if in the course of other programmes the issue of alcohol could be mentioned and elaborated upon seeing the response and circumstances. Prohibition had always been a miserable failure wherever it had been enforced. Creating awareness among the male members of a community was of little help as past evidence shows. Holding de-addiction camps was again a way of singling out the drinkers. This was effective to a certain degree but large % ages of relapses are certain in these situations. For instance he spoke of a village in Orissa where the women folk had succeeded in stopping the sale of alcohol. The result was that the men folk were now not available having made alternate arrangements in a neighboring village. Such drastic steps were not effective in the long run, he felt.

Why do men drink in the first place? This was a question that came from Ms. Padmasini Asuri. A very valid question. Dr. Benegal gave some reasons- To get Intoxicated was the prime reason, he said. There were also numerous traditional myths coming down the ages, associated with drinking. Some even encouraged it. Stating alcohol as a medicine, aphrodisiac or tonic . Though modern research shows contrary evidence. One of the interventions has always been reduce supply and demand will reduce. One important thing Dr. Benegal pointed out was that generally the emphasis of those addressing alcohol problems was on the 4% of alcohol dependant people who caused only a fraction of the problems arising out of alcohol abuse. The 40-50% who comprised of problem drinkers caused 90% of the problems i.e. violence, accidents etc. and yet were not thought of as having a problem. It is this segment of drinkers that needs to be approached. Dr. Latha Jagannathan suggested that working with school children could be considered and that this was a factor which many tended to ignore. This would be helpful, seeing that children being brought up in that environment being made aware of the dangers of alcohol would tend to stay away from it.

Dr. Pratima Murthy suggested identifying one small community and trying out whatever initiative and plan of action that would evolve from further meetings. The involvement of the community, she said, has to be given priority. She also felt that one of the main reasons for this problem was the lack of adequate recreational/ alternative activities. Members of a particular community could be asked to share their views and entire families could be involved. This is a very viable and practical idea. Mr. Rajendran felt that sitting with the people and sharing ideas was essential to the success of any proposed project. What they wanted, their likes and dislikes what alternative activity could merge with their culture and way of living would be an effective way to come up with a strategy. There were other very practical and useable ideas by all the participants. The entire group however agreed on one basic factor- alternative ways of coping with day to day adverse socio-economic situations that led many of these slum residents to drinking, would have to be thought of. Entertainment, different forms of recreation and relaxation, that the affected people think useful should be adopted. Helping the person utilize his free time more fruitfully, instead of succumbing to boredom or inactivity should be a priority.

Finally Dr. Mohan Isaac summarized the discussions session with the following points:

Alternate forms of coping
School Children
NGOs work with men?
Remove popular myths?
Women/children programs – can become entry points
Empowering families as a whole – a sense of unity – family oriented
Awareness ?

One point that was noted was that almost all of the NGOs worked with women and children. What about an NGO that worked with men? An idea worth considering. It was finally decided that there should be more meetings to try and evolve an action plan. Dr. Mohan Isaac suggested that a network could be formed, comprising of NGOs and individuals who consider the problem of alcohol abuse worth working for. CHC as an organization dealing with community and public health (and alcohol is certainly a community / public health issue) could consider initiating or facilitating a project. Funding could be thought of once a proper project evolved and a project proposal made. Some of the ideas which could be worked upon are -

Identifying one community A small group.
Interacting with them to get to know their likes and dislikes, their traditions and way of life.
Involve them in meetings to ask them their views on certain issues, especially alcohol. Ask them what they would consider as enjoyable activities or recreation.
And empower them – not women and children alone- but men also, to try and actively participate in programmes that they themselves have thought of.
And monitor and record / document the entire initiatives' progress.

So, taking into consideration all of the above thoughts and ideas, we could call for another meeting around the second week of July 2001. This will give us all enough time to think about more possibilities which we can share during our next meeting.

Participants:
Mr. Joe Paul (REDS); Dr.P.M.Unnikrishnan (FRLHT); Ms. Pushpalatha (APSA);
Mr. Bhimashankar (APSA); Sr. Elise Mary (Navajeevan); Ms. Kamakshy (APD);
Ms. Padmasini Asuri (CHC), Ms. Rani (APD); Ms. Mary and Ms. Gracy (REDS);
Dr. Mohan Isaac; Dr. Vivek Benegal and Dr. Pratima Murthy (NIMHANS); Dr. Latha Jagannathan (Rotary TTK BB); Mr. S.D. Rajendran and Mr. Arjun Krishnan (CHC)

MH-26-21

SECOND MEETING OF ACTION GROUP FOR SOBRIETY HELD AT NIMHANS ON 27TH JULY 2001.

The meeting commenced with **Dr. Pratima Murthy** welcoming the gathering and initiating the discussion. **Mr. Rajendran** (CHC) began with reminding the participants that this meeting had been called to specifically address the following issues:

- Specific Area / Locality (for implementation) and its ethnic composition
- Details about the residents' culture, prevailing traditions, likes & dislikes
- Current ongoing development programmes if any
- The resident's views on alcoholic problems and programmes they would like to adopt to address the problem
- Their views on any recreational activities

Mr. Rajendran also emphasized the need to tackle this issue at both macro and micro levels. He felt that addressing the alcohol issue at the policy level is also important to put pressure on governments and respective departments.

After **Dr. Sampath Krishnan** read out the main points of the last meeting, **Dr. Pratima Murthy** requested the group to present the basic information collected from their work areas. **Sr. Elise Mary** of Mahila Pragati Kendra began by saying she had information about the Jayarajnagar slum just behind Infant Jesus church in Austin Town. She said they had identified 25 families which could be a potential group to work with. She further elaborated on the situation saying that most of the women there were domestic workers with alcoholic husbands. This had resulted in incidents of severe domestic violence and other related problems.

At this point **Mr. Joe Paul** of REDS intervened saying that the area **Sr. Elise Mary** was talking about was not exactly a slum but rather a lower middle class area. It comprised a population that saw growth as a need. Education among the adolescent boys was fairly good and schooling was popular. However the lack of jobs, led these young people to take to crime and the main problem was a rise in criminal activity. Politics also played a big role in the life of the residents in this area. As the views expressed by both participants presented quite a contradictory picture of the Jayarajnagar slum, **Dr. Vivek Benegal** told the group that there was a need for a ***defined area*** where work could be initiated. By this ***defined area*** he meant a particular group which is facing a problem with alcohol; a potential group with which we could work with. He also felt that selecting a particular pocket in a large area would only diffuse the effect of the proposed program as the surrounding environment also played a vital role when trying to sustain a particular project. He also felt that if there was a strong political leaning in the area, implementing an alcoholic program could be a problem.

SBR/AK

1. It is good to have this type of detailed minutes capturing issues + identifying follow-up action
2. Need to identify who will take responsibility
3. A meeting in CHC could take stock of where we are + do some. Please our own planning, evolving community based approaches. Please read the Sodahalli Dasu Hubli Morcha work + campapproach & Chavai grp (TN) Have collected a resource file on Alcohol + Health – Community approaches.

RN for info/comments

Jly 2/8

AK 10/8

Dr. Sampath Krishnan (CHC) also suggested that one of the approaches for tackling alcoholism was the emphasis on spiritual health. Positive values could be taught to these people. **Dr.Vivek Benegal** felt that this approach though promising and helpful, would only create more problems, as fundamentalists of religions were always on the look out for such type of activity to jump in and destabilize the environment. These groups would find ways to sabotage any religious/spiritual approaches. It was dangerous ground to tread on under the circumstances**. Dr. Krishnan** also felt that lobbying at higher levels was a necessity as most liquor shops were flouting rules.. Especially the timings laid out by the Government regarding the stipulated opening and closing of liquor shops. Once these cases were documented and presented before the authorities there was some chance of action being taken against the erring party This was agreed upon. Another point he raised was about the funds being used by the Women and Child Development department for de-addiction. The Health & Family Welfare department currently runs about 6 rehabilitation centers in the city and these funds were being channeled for their use. It was decided to follow this up with the Women and Child Development department to find out whether any funds could be generated toward a proposed alcohol de-addiction programme.

While communicating with them copies of the minutes of the two meetings held at NIMHANS should also be sent to them. He also felt that documentation of all illegal activities by liquor shops would be a great help while macro level lobbying. **Dr. Krishnan** also suggested that training of NGO staff in methods of counseling affected families especially women could help curtail their present antagonistic behaviour toward the men which was one of causes which led to their indulging in sudden binges.

Sr. Sahage of Kanthi Kiranam said that they were working in Ragigudda slums in JP Nagar with 1400 households and more than 4000 population. She said in their experience the problem of alcoholism was quite high as majority of the men and women there consumed alcohol. She also mentioned that they had conducted a de-addiction programme in collaboration with NIMHANS some time ago. The patients had been given free nutritious meals, courtesy World Vision and had been asked to report once a week for counseling. However even though their turn out was substantial, it was noticed that they arrived just to eat the free food and not for serious counseling. The program had not been successful.

Dr.Vivek Benegal wondered whether it was feasible to work with a small group in one part of this large area and especially within a big population like this one. He even suggested that as needs of big and small groups were different we could consider working in both large and small slums for purposes of comparison. . He also suggested mapping of the area. A pattern of alcohol use could be ascertained. Alternatives the community would like to participate in could be a place to start.

Mr. Bhimashankar from APSA mentioned that they had noticed that this was an issue of concern even among street people. Whatever they earned was spent on alcohol and most of the time the women folk were forced to part with money. Dr. Benegal said that the problem with this kind of nomadic population was more severe and it was very difficult to work with them as this segment did not have a regular base and they were constantly on the move. Hence it would be very difficult to implement long term programmes with them.

Dr. Pratima Murthy said a community needs assessment would be a useful exercise as it gives a lot of information about a community and their expectations. This assessment should collect the following information, she suggested:

- *Socio-demographic details of the slum*
- *Alcohol use habits in the slum*
- *Possible, positive alternatives for the alcoholic problem.* She even suggested that if possible to include inter actors present in the area .

Dr.Pratima also said that she has a Performa which could be used to determine the socio-demographic status in a slum. She had earlier talked about the relapse rates of NIMHANS which she estimated to be about 50-60%. It was then suggested to have a follow up team among NGOs working in areas where these relapsed patients lived. These NGO members could locate these patients and see how they were progressing and whether they required any further help.

At this point **Mr. Chander** , CHC, thought that the needs based questionnaire of the **People's Health Dialogue** could possibly get a few answers. This was planned as a part of **Janaarogya Andolana** and could be used as tool. **Mr. Prahalad** (CHC) also expressed the view that any information gathering if done on the However **Dr. Pratima** was of the opinion that though it was a useful idea, it encompasses a large number of issues while alcohol constituted only a small component of it. She however agreed to go through the questionnaire and modify it to suit the present requirement. She also said that when going to the community to determine their needs, care must be taken not to allow raising their expectations

Thanking everyone for sharing their views, **Mr. Arjun** (CHC) suggested that until the next meeting the group could make a concentrated effort to find out about the existing trend of alcohol consumption and related problems in the particular slums they worked in and attempt to identify a particular group. A group which could serve as a starting point for the evolving action plan. A sample questionnaire would be prepared and sent to everyone in the group so that the required information would be available at the next meeting. We could then have some positive ideas on alternatives and action. It was decided to meet again on the 16th of August, Thursday when some more concrete information would be available.

FOLLOW UP ACTION

NGO members working in communities could begin finding out current trends of alcohol consumption and related problems their respective areas and present their findings at the next meeting.

A letter should be mailed to WCD department asking if funds were available if a feasible project plan / initiative was forwarded to them.

Dr. Partima Murthy would have a sample questionnaire ready (needs based) which could be used by the NGO members in their work areas.

NGO members would try and identify a specific group and based on their responses an action plan could evolve.

The NGO members would also note down the exact timings of the opening and closing of the liquor shops in the locality. And the respective government department could be contacted to find out about the rules that these liquor shops are supposed to follow.

NGO members would try and determine the needs of the community (related to alcohol) with whom they work without raising any of their expectations.

Dr. Vivek Benegal Dr. Pratima Murthy	}	**NIMHANS**
Sr. Elise Mary	-	**Navajeevan Mahila Pragati Kendra**
Mr. Joe Paul Mrs. Gracy Ms. A Kauhalya Ms. Jabeena Taj	}	**REDS**
Sr. Sahage CM	-	**Kanthi Kiranam**
Mr. Bhimashankar Mr. Manjunatha	}	**APSA**
Dr. Sampath K Krishnan Mr. S.D. Rajendran Mr. A. Prahalad Mr. S.J. Chandar Mr. Arjun Krishnan	}	**Community Health Cell**

MH-26.22

THE THIRD - ALCOHOLISM CONTROL IN SLUMS – MEETING AT NIMHANS
16th August 2001 (Thursday) 2:30 p.m.

The meeting began with **Mr. Rajendran (CHC)** welcoming the participants. Some of those who attended the last meeting had not come due to some prior commitments. **Dr. V. Benjaim, A. Prahlad, S.D. Rajendran and Arjun Krishnan** from **CHC** attended. **Mr. Joe Paul(REDS), Sr. Elise Mary(NMPK), Sister Sagaye (Kanthi Kiran) and Mahesh (TREDA)** had brought the needs assessment information needed as discussed at the last meeting. **Dr. Vivek Benegal NIMHANS** requested **Dr. V. Benjamin** to chair the meeting. Dr. Benjamin stated that though he had not been present for the previous meetings he was interested in the whole process. For the presentations **Dr. Benegal** had arranged an overhead projector which made it easier for the speakers to present their findings. He asked **Sr. Sagaye** to begin with her presentation of the Ragigudda Slum near J.P. Nagar, where she and her group work.

Ragigudda This slum established in 1970 now has more than 1400 houses and is located near the up market JP Nagar area. The residents belonging originally from Chikmagalur, Tamilnadu and Andhra Pradesh speak predominantly Tamil followed by Telugu, Kannada and Urdu. While the majority of women work as housemaids, the rest sell vegetables, flowers and are employed in garment factories, the men work as carpenters, coolies, plumbers and painters. The women bring home about Rs. 200/ to Rs. 300/- per month and the men earn about the Rs. 50/ Rs.60/- per day whenever they get part time jobs. There are an average of three children per household and very few joint families Though it is a regularized slum, the land belongs to KSRTC, BDA and a portion to private owners. There are two borewells and very few have water connections at home. The water supplied from the Bangalore City Corporation comes only on alternate days. The drains are open and there are public toilets used mainly by the women folk, as most of the male population prefers to go outdoors.

Of the houses in the slum about 500 are semi-pucca while the rest have thatched roofs About 200 of these houses have their own toilets. One out of ten houses have access to cable TV. **Dr. Vivek Benegal** felt that TV was an important factor to consider as it influenced attitudes and behaviour. **Sr. Sagaye** also noted that during the last five years living conditions had not improved at all.

Formal and non formal education was available. One school offers education up to the 10th grade. There was a Government school where though the students were provided school uniforms there was no sign of any regular teaching being conducted. A number of primary schools also were functioning in the area. An NGO - World Vision offered financial help to some families for education but this was not enough as the major portion of school fees had to be borne by the parents which they could not manage. The result was that very few availed of this aid. Not all children were attending school due to primarily three reasons:

- Have to take care of their siblings
- Lack of money to pay fees
- Poverty

Dr. Benegal said that he knew of certain government requirements for Urban slums. These could be looked into. When asked about community health, **Sr. Sagaye** said that the most prevalent ailments were cough, cold, fever, Asthma and Jaundice. There was an IPP center about 20 minutes away and there was a once a week clinic being run by REDS. Many patients were often referred to St. John's or Rajiv Gandhi Hospital as they were given concessions. There were about four to five private clinics all run by MBBS doctors.

There were about 15 to 20 illicit liquor shops operating within the slum. **Dr. Benegal** informed the group that there were three types of alcohol available –
the Government Arrack shops and the IMFL private liquor shops both of which were legal while the other two were illegal being sold in sachets without a stamp or in open bottles corked with lids made out of paper. According To **Sr. Sagaye**, there was only one legally run liquor shop close by. Within the slum, two families brew liquor though they are scared of the police. Majority of the men drink alcohol while a quarter of the women population also consumes it. For income generation, self-financed petty business exists. There was no agency giving loans save for World Vision which had extended a few housing loans. For recreation, TV and gambling seemed to be the only avenues open to the people. The unemployed are mainly youth. Seasonal jobs are prevalent and most of the men prefer this. While most of the men smoke quite a few women chew tobacco. There was also the use of inhalants (typewriter correction fluid) beside some other drugs. Suicide was quite frequent and only last Sunday about four people killed themselves. The reasons were different. Ranging from an unfulfilled love affair to a family quarrel. Sex Workers were operating from the slums but not conducting business within it. When asked by **Dr. Benegal** about the prevalence of HIV/AIDS, **Sr. Sagaye** said there was no real information or statistics on this problem. Movies were also popular among the youth who often were seen going to theatres in the evenings.

Only one-room houses existed and there was hardly any privacy. Husband wife quarrels are common due to the problems of unemployment, worries, lack of any proper recreation and unfulfilled needs. Community fights were rare, the last one having occurred about six years ago.

Dr. Benegal by then had divided the report into separate sections namely

Housing
Sanitation
Nutrition
Education – Adult, Children
Health –
Income generation

He said that he knew of many agencies who financed schemes in these areas. For instance. Infosys and Wipro had two foundations, which helped underprivileged people. They could be approached for any intervention which may come up.

The Department of Women and Child Department has self financing schemes for women's activities, most of which are not tapped. Most of these unutilized funds are either returned to the Central Government or misused. **Joe Paul (REDS)** informed the group that some private foundations had a MOU with the Karnataka Government. Through which they financed only specific projects or schemes. However **Prahalad (CHC)** said that they also had other budgets and did not know where and how to use them. **Dr. Benegal** said that Institutions like NIMHANS and St. John's good offices could be used to obtain funds for certain priority programmes. Akshara is an educational society which works in disadvantaged areas and could be approached. The Department of Sports and Youth Development could also be approached to find out whether they could be of help in terms of providing suggestions for the youth in the slums. **Dr. Benegal** also felt that the alcohol control group could select a core group who should approach the appropriate authorities as a collective forum. The group could also find out about the government's commitments made to the Task Force on Health with regard to alcohol control. Certain medical colleges were adopting slums for sending final year students to work in who were sent in batches to a defined area. These students could be used in the proposed intervention. Some kind of infrastructure has to be worked into the plan and while the group ran the programme the institutions could be asked to help out. **Prahlad (CHC)** said that St. John's and KIMS' Department of Community Medicine to could be approached for the intervention. CHC could possibly facilitate this process.

Jayaraj Nagar C

Sr. Elise Mary was next to present her report on the Jayaraja Nagar near Austin Town. This slum, a corporation approved one, had a population of about 4000. 90% were Tamils and 10% Kannadigas. The men worked in the painting and hotel trade. The women were mainly domestic workers and a few were in the tailoring industry. Their wages amounted to Rs. 75 per day for men and Rs. 20 for women per day. Housing comprised of 90% semi-pucca houses and 10% pucca houses and all are electrified. 90% of the residents have yellow ration cards and 10% green. The literacy rate is about 75% (10^{th} std. And PUC). Anganwadis are properly run and maintained. Water borne diseases are quite common. Health facilities were available through the corporation's maternity welfare centers which were close by (200 yards).

Regarding alcohol, 90% of the men drank and caused related family and domestic problems. Family quarrels are common. The reasons for liquor consumption are mainly : family and personal problems, unemployment and under employment, hard work, lack of any enjoyment, social functions used as events to drink and unsuccessful love affairs. 60% used tobacco. 50% of the youth were unemployed and gambling is common among them. Legally sold liquor was available 200 yards away from the slum, while illicit hooch was also available in the slum itself. People are not aware of the health consequences of tobacco and alcohol consumption. The main reasons for domestic violence are liquor consumption, unemployment and poverty and extramarital relationships. The slum has a women ***sangha*** with 75 members, a Youth club which helps in organizing religious functions etc. and Helping Hand a group of 35 people. The women face enormous problems with the present alcohol consumption situation.

However compared to the other slums suicides were uncommon. Sr. Mary felt that the problem can be lessened by creating employment opportunities besides initiating recreational activities and awareness campaigns. At present there was no income generation activity within the slum. The corporation councilor is also the local political leader.

Joe Paul's view of the same slum was a bit different. He said that it was a developing slum in the sense that the population comprising of lower middle income groups and those holding government jobs, were progressive. More education and career oriented. Though Sr. Mary's report projected a different picture. Anyway **Dr. Benegal** said that the Ragigudda and the Jayarajnagar slums represented two different areas with two different populations. And these could be considered as place to experiment with the new interventions. Dr. Benegal had to leave after this to attend a staff meeting saying he would try and return.

The third presentation was by **Mr. Joe Paul of REDS**. He had a sample survey of two slums (Byrasandra and Satiyeval Nagar) both of which radically differed in statistics. With the use of the overhead projector, Mr. Joe Paul showed us the differences in the two slums. While the statistics contained all the regular information about both the slums especially the number of years they had existed, the population, the basic needs etc. the main area of focus was the residents affected by alcoholism and some of the reasons for it. Wages was an important factor. While in Byrarsandra the workers depended more on luck than any other thing, and they did earn good wages whenever they could, (extortion was reported to be one of the ways they eared money) the workers in Satiyeval largely women, worked regularly yet earned very meager wages. Educational facilities were availed of by the Satyivel population who thought learning was essential, but the Byrasandra population avoided the schools. The reason was lack of motivation. Regarding the health status- Alcoholism Burn cases and mental cases formed the majority of cases in Byrasandra. Mr. Joe Paul referred to them as Hard Core Psychopaths who needed an entirely different approach. No women sanghas existed there. TB, Cancer and accident cases were also reported. In Satiyeval the health problems constituted Gynae cases, alcoholism, malnutrition and bad sanitation. REDS ran a once-a-week clinic There were women sanghas and a youth group. These residents however faced the constant threat of eviction as the land they lived on was under dispute. They urgently required the comfort of Tenancy Rights. On the other hands the Byrasandra populace was constantly confronted by the Police and experienced constant surveillance by them. There were a number of illegal liquor shops operating within the slum. The reason for widespread alcoholism was the attitude of masochism that the residents nurtured. The reasons for alcoholism in the other slum were completely different, Here they were fatigue, sickness, and poverty. There were fewer liquor shops here.

What was needed was 'behaviour modification in the Byrasandra slum. They needed some kind of mental health programme to help them. There were a lot of sex workers also operating from here. The men drank and gambled. The women drank and slept while the children loitered around. Byrasandra was also considered a safe place to seek refuge after committing a crime.

In Satiyeval the men would get occasional employment and the entertainment was of a different kind here. Watching TV, films and playing cricket, Carom and cards were common. However the youth would indulge in petty theft. The women are empowered and are doing what they can to improve conditions.

Mr. Mahesh of TREDA spoke briefly on the Tarakaramanagar slum near Nellurpuram which has been in existence for the last 40 years. There about 700 houses with a population of about 3000. The majority speak Telegu (85%), 10% Tamil and 0.5% Kannada. The nearest hospital is HAL and there are two private practitioners. The common health problems are malaria, cholera and diarrhea. The main occupation of the men folk is casual labour and 40% of them drink regularly. Crimes are extremely rare and there have been no reports. There is a Dr. Ambedkar Social Welfare Union within the slum. All the houses are electrified though there are no proper roads. There is a Fair Price shop selling rice, wheat and Kerosene. There are 12 public toilets (6 for men and 6 for women) but these are in a very bad condition. 30 houses have concrete roofing while the rest are tiled or have coconut thatch. 8 drug addicts have been identified. For education there is one primary school and one middle school and no high school.

Finally after discussions it was decided that in the next meeting the following would be discussed and decided. In the meanwhile the group was asked to think of any possible intervention which could be discussed.

Follow Up Action Proposed

At the next meeting we invite some of the patients and their relatives from the NIMHANS De- addiction ward, some members of AA (Alcoholics Anonymous) and others to give their views.

A plan of action could materialize once it was decided on

What kind of human resources were available
What kind of framework and time limit was needed to implement a programme
What kind of financial requirements were needed.

It was also felt that the presence of Dr. Mohan Isaac, Dr. Vivek Benegal and Dr. Pratima Murthy was essential to the formation of a programme and that could only be evolved when they were present.

In the meanwhile all the participants were urged to come up with specific ideas of an experimental alcohol control programme which could work in any one or two slums out of the ones mentioned in this meeting.

At the next meeting we could consider the different plans which members of the group came up with.

Participants in the meeting

Dr. Vivek Benegal	NIMHANS
Sr. Sagiye	Kanthi Kiran
Sr. Elise Mary\ Ms. Kanige Ms. Lurdammal	Navajeevan Mahila Pragati Kendra
Mr. Joe Paul Sr. Gracie	REDS
Dr. V. Benjamin Mr. A. Prahalad Mr. S.D. Rajendran Mr. Arjun Krishnan	Community Health Cell
Mr. Mahesh	TREDA

MH-25.24

DRUG ABUSE PROBLEM IN MANIPUR (NORTH EAST STATE)
DR. JAYANTA KUMAR, GALAXY CLUB, IMPHAL

The North East States comprises of Manipur, Mizoram, Meghalaya, Nagaland, Assam, Arunachal, Tripura and Sikkim. Manipur is one of the eight sister state of the North East India.

Of these, Manipur is one of the underdeveloped states of the country. There is no factory or industry worth its name. There is no train connection. Bus services are available through Nagaland but frequently disturbed to due law and order problems and ethnic clashes. However, air connection is available between Gawhati and Calcutta. Unemployment is a very severe problem in the state. Out of the 18 lakh population, the state employment exchange has registered 4 lakh individuals as being unemployed. Non-availability of raw material, poor power system, unstable law and order, frequent bundh, etc. has also severely crippled self employment schemes. Drugs peddling has become a very common means of livelihood. The state voluntary organisations have estimated that there are about 30,000 drug addicts in the state.

Drug abuse scenario in the state of Manipur

The nature of drug abuse in this tiny state is very different from the rest of the country. Socioeconomic, demographic status and pattern of drug abuse of 2650 drug addicts treated at the de-addiction centre run by the Galaxy Club at Imphal is as follows:

Age group	Upto 25 years	32%
	26 to 35 years	57%
	36 years and above	11%

89% of the drug addicts are youths

Educational level	Upto High School	31%
	Upto Higher Secondary	42%
	Graduate and above	23%
	Illitcratc	01%

99% of drug addicts are educated

Occupation	Unemployed	84%
	Employed	16%

Unemployment is a major cause of addiction

Family income	Upto Rs.2000 p.m.	28%
	2001 to 4000 p.m.	43%
	Rs.4001 and above	29%

71% of the family cannot afford complete treatment

Chemical of choice	Heroin with other drugs	87%
	Alcohol	13%

Heroin is always the drug of choice

Mode of use	Injecting	79% (sharing of syringes 82%)
	Chasing	07%
	Oral	14%

Injecting carries risk of HIV and other complications

Problems encountered

a) The attitude of pressure groups like insurgents, students union, Mera Palbis, Village Chiefs etc. towards drug addicts is still negative. Shooting of drug addicts, raiding houses of drug addicts, parading them on the streets etc. are common scenes.

b) Due to the poor economic condition of the family most clients are discharged even before completion of treatment.

c) Due to frequent raid by pressure groups, the clients migrate and follow-up becomes very difficult.

d) Poor and ineffective telephone and postal systems, and the poor road conditions make follow-up very difficult.

e) There is a severe shortage of man power in the various service centres. Hardly 15% of the staff in the service centres have received training.

f) There is a high influx of drugs due to legalised trading routes with Myanmar.

g) Medical complications like injection abscess, gangrene etc. are very common. HIV-AIDS is a very severe problem that complicates issues (60% of HIV positive cases are from IDU's).

h) Due to the poor economic condition of the state, resource mobilisation is very difficult.

i) Work placement for job facilities are very difficult as there is no factory / industry.

What needs to be done

Human resources

1. Developing a local based Regional Resource Training Centre to impart training for all project staff to help them understand the ground needs and ensure sustainability of the programmes.

2. Identifying established centres for field exposure

3. Identifying training needs and develop a training calendar to offer training on a continued basis.

4. Meet at least once a year to review and revise the quality of training and its impact.

Material resources

1. Improving the communication and documentation system by providing e-mail etc.

2. Developing good I.E.C. material, news letter

3. Providing access to good books, manuals etc. for the staff

Financial resources

1. Flow of grant to be regular and ensure sanctions in due time by minimising the state level procedures.

2. Grant needs to be 100% as local resource mobilisation is very difficult

The Government of India scheme should also address the following:

1. Encourage NGOs that offer good services by waiving state recommendations and encouraging innovative schemes.

2. Scheme for opening drop-in-centres, half way homes etc. as well as encouraging other relapse prevention strategies. Recreational facilities are almost nil in the northeast and resources need to be allocated to offer the same.

3. Vocational / income generating programmes should be an integral part of the scheme as unemployment is a major cause of relapse. The ILO project could be reference to this.

4. Revision of the scheme should be carried out every three years, especially the staff salary structure to prevent drop out amongst staff.

IMMEDIATE NEED FOR THE NORTH EAST STATES

1. DEVELOP A TRAINING CALENDAR
(At least 60% staff should be training)

2. IMPROVE THE COMMUNICATION SYSTEM
(provide E-mail, IEC materials, News letter, Reference books)

3. RELAPSE PREVENTION STRATEGIES (Pilot study)

a) Half way home, Drop in centre
b) Vocational / income generating scheme
c) Advocacy for pressure group and community leaders

4. TRAINING TO BE CONDUCTED EVERY YEAR TO BUILD AND EMPOWER TEAMS TO IMPROVE THE PROGRAMME

Brief CV of Dr. Jayanta

Working in the field of Drug Abuse Prevention for the past 12 years.

Given training to many NGO / CBOs at state, North east and National level

Trainer on intervention programme of State AIDS Society, Manipur

Exposure to Bangkok, Hongkong, Singapore, Malaysia, U.K. on drug related programmes.

Acted as resource person and present numerous papers on Drug and HIV related issues at national and international level.

THE USELESS EMOTIONS - GUILT AND WORRY

If you believe that feeling bad or worrying long enough will change a past or future event, then you are residing on another planet with a different reality system.

Throughout life, the two most futile emotions are guilt for what has been done and worry about what might be done. There they are! The great wastes - Worry and Guilt - Guilt and Worry. As you examine these two erroneous zones, you will begin to see how connected they are; in fact they can be viewed as opposite ends of the same zone.

X _____ Present _____ X
Guilt (PAST) (FUTURE) Worry

There you have it. Guilt means that you use up your present moments being immobilized as a result of past behavior, while worry is the contrivance that keeps you immobilized in the now about something in the future - frequently something over which you have no control. You can see this clearly if you try to think of yourself as feeling guilty about an event that has yet to occur, or to worry about something that has happened. Although one response is to the future and the other to the past, they both serve the identical purpose of keeping you upset or immobile in your present moment. Robert Jones Burdette wrote in Golden Day:

It isn't the experience of today that drives men mad. It is the remorse for something that happened yesterday, and the dread of what tomorrow may disclose.

You see examples of guilt and worry everywhere, in virtually everyone you meet. The world is populated with folks who are either feeling horrible about something that they shouldn't have done or dismayed about things that might or might not happen. You are probably no exception. If you have large worry and guilt zones, they must be exterminated, spray-cleaned and sterilized forever. Wash out those little "w" and "g" bugs that infest so many sectors of your life.

Guilt and worry are perhaps the most common forms of distress in our culture. With guilt you focus on a past event, feel dejected or angry about something that you did or said, and use up your present moments being occupied with feelings over the past behavior. With worry, you use up those valuable nows, obsessing about future event. Whether you're looking backward or forward, the result is the same. You're throwing away the present moment. Robert Burdette's "Golden Day" is really "today," and sums up the folly of guilt and worry with these words.

There are two days in the week about which and upon which I never worry. Two carefree days, kept sacredly free from fear and apprehension. One of these days is yesterday . . . and the other day I do not worry about is tomorrow.

A CLOSER LOOK AT GUILT

Many of us have been subjected to a conspiracy of guilt in our lifetimes, and uncalculated plot to turn us into veritable guilt machines. The machine works like this. Someone sends out a message designed to remind you that you've been a bad person because of something you said or didn't say, felt or didn't feel, did or didn't do. You respond by feeling bad in your present moment. You are the guilt machine. A walking, talking, breathing contraption that responds with guilt whenever the appropriate fuel is poured into you. And you are well oiled if you've had a total immersion into our guilt-producing culture.

Why have you bought the worry and guilt messages that have been laid on you over the years? Largely because it is considered "bad" if you don't feel guilty, and "inhuman" not to worry. It all has to do with CARING. If you really care about anyone, or anything then you show this concern by feeling guilty about terrible things you've done, or by giving some visible evidence that you are concerned about their future. It is almost as if you have to demonstrate your neurosis in order to be labeled a caring person.

Guilt is the most useless of all erroneous zone behaviors. It is by far the greatest waste of emotional energy. Why? Because, by definition, you are feeling immobilized in the present over something that has already taken place, and no amount of guilt can ever change history.

DISTINGUISHING GUILT FROM LEARNING FROM THE PAST

Guilt is not merely a concern with the past; it is a present moment immobilization about a past event. And the degree of immobilization can run from mild upset to severe depression. If you are simply learning from your past, and vowing to avoid the repetition of some specific behavior, this is not guilt. You experience guilt only when you are prevented from taking action now as a result of having behaved in a certain way previously. Learning from your mistakes is healthy and a necessary part of growth. Guilt is unhealthy because you are ineffectively using up your energy in the present feeling hurt, upset and depressed about a historical happening. And it's futile as well as unhealthy. No amount of guilt can ever undo anything.

THE ORIGINS OF GUILT

There are two basic ways in which guilt becomes a part of the emotional makeup of an individual. In the first, guilt is learned at a very early age and remains with a grown-up as a leftover childish response. In the second case, guilt is self-imposed by an adult for an infraction of a code to which he professes to subscribe.

1. Leftover Guilt. = This guilt is the emotional reaction which is carried around from childhood memories. There are scores of these guilt producers, and while they work in that they produce results in children, people still tote around these sentences as adults. Some of these leftovers involve admonoitions like:

"Daddy won't like you if you do that again."
"You should feel ashamed of yourself." (As if that will be helpful to you.)
"Oh, all right. I'm only your mother."

As an adult, the implications behind these sentences can still produce hurt if a person disappoints his boss, or others whom he has made into parents. The persistent attempt to win their support is there, and so is the guilt when the efforts are unsuccessful.

Leftover guilt also surfaces in sex and marriage. It can be seen in the numerous self-reproaches and apologies for past behavior. These guilt reactions are present as a result of learning to be manipulated by adults in childhood, but they can still operate when the child has grown up.

2. Self-imposed Guilt. = This second category of guilt reactions is a much more troublesome area. Here the individual is being immobilized by things he has done recently, but which are not necessarily tied to being a child. This is the guilt imposed on the self when an adult rule or moral code is broken. The individual may feel bad for a long time even though the hurting can do nothing to change what has happened. Typical self-imposed guilt includes having told someone off, and hating one's self for it, or being emotionally drained in the present moment because of some act such as shoplifting, not going to church, or having said the wrong thing in the past.

Thus you can look at all of your guilt either as reactions to leftover imposed standards in which you are still trying to please an absent authority figure, or as the result of trying to live up to self-imposed standards which you really don't buy, but for some reason pay lip service to. In either case, it is stupid, and, more important, useless behavior. You can sit there forever, lamenting about how bad you've been, feeling guilty until your death, and not one tiny slice of that guilt will do anything to rectify past behavior. It's over! Your guilt is an attempt to change history, to wish that it weren't so. But history is so and you can't do anything about it.

You can begin to change your attitude about the things over which you experience guilt. Our culture has many strains of puritanical thinking which send out messages like, "If it's fun, you're supposed to feel guilty about it." Many of your own self-inflicted guilt reactions can be traced to this kind of thinking. Perhaps you've learned that you shouldn't indulge yourself, or you must not enjoy a dirty joke, or you ought not to participate in a certain kind of sexual behavior. While the restraining messages are omnipresent in our culture, guilt about enjoying yourself is purely self-inflicted.

You can learn to savor pleasure without a sense of guilt. You can learn to see yourself as someone who is capable of doing anything that fits into your own value system and does not harm others and doing it without guilt. If you do something, whatever it may be, and you don't like it or yourself after having done it, you can vow to eliminate such behavior for yourself in the future. But to go through a self-inflicted guilt sentence is a neurotic trip that you can bypass. The guilt does not help. It not only keeps you immobilized, but it actually intensifies the chances that you'll repeat the unwanted behavior. Guilt can be its own reward as well as permission to repeat the behavior. As long as you retain the potential payoff of absolving yourself with guilt, you'll be able to keep yourself in that vicious treadmill that leads to nothing but present-moment unhappiness.

TYPICAL GUILT-PRODUCING CATEGORIES AND REACTIONS

PARENTAL GUILT ON CHILDREN OF ALL AGES

Manipulating the child to complete a task through guilt:

Parent - "Donny, bring up the chairs from the basement. We'll be eating soon."

Child - "O.K., Mom, in a minute, I'm watching the ball game and I'll do it when this inning is over."

Parental guilt signal - "Never mind then, I'll do it with my bad back. You just sit there and enjoy yourself."

Donny has visions of his mother falling down with six chairs landing on top of her. And he's responsible.

The "I sacrificed for you" mentality is an exceedingly effective guilt producer. Here a parent can recall all the hard times in which he gave up his happiness so that you might have something. You naturally ask yourself how you could be so selfish after you've been reminded of your debts. References to the suffering of childbirth are one example of this guilt-producing attitude. "I went through eighteen hours of labor just to bring you into the world." Another effective statement is, "I stayed married to your father because of you." This one is designed to make you feel guilty for Mama's bad marriage.

Guilt is an effective method for parental manipulation of a child's actions. "That's okay. We'll stay here by ourselves. You just enjoy yourself the way you've always done. Don't worry about us." Statements like this are effective in getting you to telephone or visit on a regular basis. With a slight twist you hear: "Whatsamatter; you got a broken finger and you can't dial a telephone?" The parent switches the guilt machine on and you behave accordingly, albeit resentfully.

The "You disgraced us" tactic is also useful. Or "What will the neighbors think?" External forces are marshaled to make you feel bad about what you've done, and to keep you from thinking for yourself. The "If you ever fail at anything you'll disgrace us" guilt excursion can make living with yourself after a shabby performance almost impossible.

Parental illness is a super guilt manufacturer. "You've made my blood pressure go up." References to "killing me" or "giving me a heart attack" are effective guilt producers, as well as blaming you for virtually all of the normal ailments associated with growing older. You need big shoulders to carry this guilt around, since it can literally last a lifetime, and if you are particularly vulnerable, you can even carry the guilt of a parent's death.

Sexual guilt imposed by parents is quite common. All sexual thought or behavior is fertile soil for the cultivation of guilt. "God forbid you should masturbate. It's bad." Through guilt you can be manipulated into the right sexual stance. "You should be ashamed for reading such magazines. You shouldn't even have such thoughts."

Socially appropriate behavior can be fostered with guilt. "How could you embarrass me by picking your nose in front of Grandma? " "You forgot to say thank you. Shame on you, do you want our friends to think I didn't teach you anything?" A child can be helped to learn socially acceptable behavior without the accompanying guilt. A simple reminder which follows an explanation of why the behavior is undesirable is much more effective. For example, if Donny is told that his constant interruptions are disconcerting and make conversation impossible, he will have the first seed planted without having the guilt that goes with a statement such as, "You're always interrupting, you should be ashamed of yourself, it's impossible to talk with you around."

Merely reaching adulthood does not put an end to parental manipulation by guilt. I have a friend who is fifty-two-years old. He is a pediatrician of Jewish extraction married to a non-Jewish woman. He keeps his marriage a secret from his mother, because he is afraid it might "kill her" or more aptly, he might kill her. He maintains a separate apartment with all of the household trimmings for the sole purpose of meeting with his eighty-five-year-old mother every Sunday. She does not know that he is married and owns his own home where he lives six days a week. He plays this little game out of fear and guilt about being married to a "Shiksa." Although he is a fully grown man who is highly successful in his own professional world, he is still controlled by his mother. Each day he talks to her from his office and lives out his bachelor fantasy.

Parental-and family-associated guilt is the most common strategy for keeping a rebellious person in tow. The examples above are only a small sample of the multitude of statements and techniques for helping a son/daughter to choose guilt (present-moment immobility over a past event) as the price of genealogy.

LOVER AND SPOUSE RELATED GUILT

The "If you loved me" guilt is one way to manipulate a lover. This tactic is particularly useful when one wants to punish a partner for some particular behavior. As if love were contingent upon the right kind of behavior. Whenever one person doesn't measure up, guilt can be used to get him back into the fold. He must feel guilty for not having loved the other.

Grudges, long silences and hurtful looks are useful methods of engendering guilt. "I'm not talking to you, that'll fix you" or "Don't come near me, how do you expect me to be loving after what you've done?" This is a commonly employed tactic in the case of straying behavior on the part of one partner.

Often, years after an incident, an action is recalled to help the other person to choose present-moment guilt. "But don't forget what you did in 1951" or "How could I ever trust you again when you let me down before?" In this way one partner can manipulate the other's present with references to the past. If one partner has finally forgotten it, the other can periodically bring it up to keep the guilt feelings about the past behavior current.

Guilt is useful in making a love partner conform to the other's demands and standards of behavior. "If you were responsible, you would have called me" or "That's the third time I had to empty the garbage, I guess you just refuse to do your share." The goal? Getting one partner to do what the other wants him to. The method? Guilt.

CHILDREN - INSPIRED GUILT

The parental guilt game can be reversed. Guilt can be a two-way street and children are just as apt to use it in manipulating their parents as the reverse.

If a child realizes that his parent cannot cope with his being unhappy and will feel guilty for being a bad parent, the child will often try to use that guilt to manipulate the parent. A tantrum in the supermarket may produce the desired candy. "Sally's father lets her do it." Therefore Sally's father is a good father and you're not. "You don't love me. If you did you wouldn't treat me this way." And the ultimate, "I must be adopted. My real parents wouldn't treat me like this." All these statements carry the same message. You as a parent ought to feel guilty for treating me, your child, in this way.

Of course, children learn this guilt-producing behavior by watching the adults in their world use it to get things that they want. Guilt is not a natural behavior. It is a learned emotional response that can only be used if the victim teaches the exploiter that he is vulnerable. Children know when you are susceptible. If they constantly remind you of things that you've done, or haven't done, for the purpose of getting what they want, then they have learned the guilt trick. If your children use these tactics, they picked them up somewhere. Very likely, from you.

SCHOOL - INSPIRED GUILT

Teachers are superlative guilt originators, and children, since they are most suggestible, are excellent subjects for manipulation. These are some of the guilt messages that produce present-moment unhappiness for young people:

"Your mother really going to be disappointed in you."

"You should be ashamed of yourself for getting a C - a smart boy like you."

"How could you hurt your parents like that, after all they've done for you?
Don't you know how badly they want you to go to Harvard?"

"You failed the test because you didn't study, now you'll have to live with yourself"

Guilt is often used in schools to make children learn certain things or behave in certain ways. And remember that even as an adult you are a product of those schools.

CHURCH - RELATED GUILT

Religion is often used to produce guilt and therefore manipulate behavior. Here, God is generally the one you have let down. In some cases the message is that you will be kept out of heaven for having behaved badly.

"If you loved God, you wouldn't behave that way."

"You won't get into heaven unless you repent for your sins."

"You should feel bad because you haven't gone to church every week,
and if you feel bad enough, perhaps you'll be forgiven."

You've disobeyed one of God's rules and you should feel ashamed of yoursef."

OTHER INSTITUTIONAL GUILT PRODUCERS

Most prisons operate on guilt theory. That is, if a person sits long enough thinking how bad he's been, he will be better for the guilt. Jail sentences for nonviolent crimes such as tax evasion citations, civil infractions and the like are example of this mind-set. The fact that a strikingly large percentage of inmates return to law-breaking behavior has done nothing to challenge this belief.

Sit in a jail and feel bad for what you've done. This policy is so expensive and useless that it defies logical explanation. The illogical explanation, of course, is that guilt is such an integral part of our culture, that it is the backbone of our criminal justice system. Rather than have civil law breakers help society or repay their debts, they are reformed through guilt-producing incarceration that has no benefit to anyone, least of all the offender.

No amount of guilt, however large, will change past behavior. Moreover, jails are not places where new legal choices are learned. Instead, they encourage a repetition of illegal behavior by embittering the prisoner. (The policy of imprisoning dangerous criminals to protect others is a different issue, and not under discussion here.)

In our society tipping is a practice that has come to reflect not superior service but the guilt of the person served. Effective waiters and waitresses, cab drivers, bellboys, and other serving employees have learned that most people cannot handle guilt for not behaving in the correct way and will tip the standard percentage regardless of the quality of service received. Thus blatant hand extending, nasty comments and looks that are designed to wither are all used to produce guilt and, fast on its heels, the big tip.

Littering, smoking and other unacceptable behavior may be things that you can be made to feel guilty about. Perhaps you've dropped a cigarette or a paper cup. A stern look by a stranger can send you into paroxysms of guilt for having behaved in such a crass fashion. Instead of feeling guilty about something you have already done, why not simply resolve not to behave in an antisocial manner again.

Dieting is an area that is loaded with guilt. The dieter eats one cookie and feels bad for a day for having been weak for a moment. If you are striving to lose weight and give in to counterproductive behavior, you can learn from it and work at being more effective in your present moment. But to feel guilty and full of self-reproach is a waste of time, for, you feel that way for very long, you are likely to repeat the excess eating, as your own neurotic way out of your dilemma.

SEXUAL EXPRESSION GUILT

Perhaps the area where guilt flourishes best in our society is in the realm of sex. We have already seen how parents engender guilt in children for sexual acts or thoughts. Adults feel no less guilty about matters of sex. People sneak into porno films so that others won't know how bad they've been. Some people can't admit to enjoying oral sex and often feel guilty for even thinking about it.

Sexual fantasies are also effective guilt producers. Many feel bad about having such thoughts and deny their existence even in private, or in therapy. In fact if I had to locate a guilt center in the body, I would place it in the crotch.

This is only a brief listing of the cultural influences that conspire to help you choose guilt. Now let's take a look at the psychological payoffs for feeling guilt. Keep in mind that whatever the dividend, it is bound to be self-defeating, and remember that the next time you opt for guilt over freedom.

THE PSYCHOLOGICAL PAYOFFS FOR CHOOSING GUILT

Here are the most basic reasons for choosing to waste your present feeling guilty about things that you've done or failed to do in the past.

By absorbing your present moments feeling guilty about something that has already taken place, you don't have to use that now moment in any kind of effective, self-enhancing way. Very simply, like so many self-defeating behaviors, guilt is an avoidance technique for working on yourself in the present. Thus you shift responsibility for what you are or are not now to what you were or were not in the past.

By shifting responsibility backward you not only avoid the hard work of changing yourself now but the attendant risks that go with change as well. It is easier to immobilize yourself with guilt about the past than to take the hazardous path of growing in the present.

There is a tendency to believe that if you feel guilty enough, you will eventually be exonerated for having been naughty. This being forgiven payoff is the basis of the prison mentality described above, in which the inmate pays for sins by feeling terrible for a long period of time. The greater the transgression, the longer the period of remorse necessary for pardon.

Guilt can be a means of returning to the safety of childhood, a secure period when others made decisions for you and took care of you. Rather than taking yourself in hand in the present, you rely on the values of others from your past. And once again the payoff is in being protected from having to take charge of your own life.

Guilt is a useful method for transferring responsibility for your behavior from yourself to others. It is easy to get infuriated at how you are being manipulated and to shift the focus for others, who are so powerful that they can make you feel anything they want, including guilty.

Often you can win the approval of others even when those others don't approve of your behavior by feeling guilt for the behavior. You may have done something out of line, but by feeling guilty you are showing that you know the proper way to behave, and are making an attempt to fit in.

Guilt is a superb way to win pity from others. No matter that the desire for the pity is a clear indication of low self-esteem. In this case you'd rather have others feel sorry for you, than like and respect yourself.

There you have the most notorious of the dividends for hanging onto guilt. Guilt, like all self-nullifying emotions, is a choice, something that you exercise control over. If you don't like it and would prefer to make it go away so that you are entirely "guilt-free" here are some beginning strategies for wiping your guilt slate clean.

SOME STRATEGIES FOR ELIMINATING GUILT

Begin to view the past as something that can never be changed, despite how you feel about it. It's over! And any guilt that you choose will not make the past different. Emblazon this sentence on your consciousness. "My feeling guilty will not change the past, nor will it make me a better person." This sort of thinking will help you to differentiate guilt from learning as a result of your past.

Ask yourself what you are avoiding in the present with guilt about the past. By going to work on that particular thing you will eliminate the need for guilt.

A client of mine who had been carrying on an extramarital affair for some time provides a good example of this kind of guilt elimination. The man professed to feel guilty about the affair, but continued to sneak away from his wife each week to see the other woman. I pointed out to him that the guilt he spoke so much about was a totally futile emotion. It did not improve his mar-

riage and even prevented him from enjoying his affair. He had two choices. He could recognize that he was devoting his present to feeling guilty because it was easier than examing his marriage closely and going to work on it - and himself.

Or he could learn to accept his behavior. He could admit that he condoned extramarital sexual exploration and realize that his value system encompassed behavior which many people condemn. In either case, he would be choosing to eliminate the guilt, and to either change or accept himself.

Begin to accept certain things about yourself that you've chosen but which others may dislike. Thus, if your parents, boss, neighbors, or even spouse, take a stand against some of your behavior, you can see that as natural. Remember what was said earlier about approval seeking. It is necessary that you approve of yourself; the approval of others is pleasant but beside the point. Once you no longer need approval, the guilt for behavior which does not bring approval will disappear.

Keep a Guilt Journal and write down any guilty moments, noting precisely when, why, and with whom it occurs, and what you are avoiding in the present with this agonizing over the past. The journal should provide some helpful insights into your particular guilt zone.

Reconsider your value system. Which values do you believe in and which do you only pretend to accept? List all of these phony values and resolve to live up to a code of ethics that is self-determined, not one that has been imposed by others.

Make a list of all the bad things you've ever done. Give yourself guilt points for each of them on a scale of one to ten. Add up your score and see if it makes any difference in the present whether it's one hundred or one million. The present moment is still the same and all of your guilt is merely wasteful activity.

Assess the real consequences of your behavior. Rather than looking for a mystical feeling to determine yes's and no's in your life, determine whether the results of your actions are pleasing and productive for you.

Teach those in your life who attempt to manipulate you with guilt that you are perfectly capable of handling their disappointment in you. Thus, if Mama gets into her guilt act with "You didn't do this" or "I'll get the chairs, you just sit there, " learn new responses like "Okay, Mom, if you want to risk your back on a few chairs because you can't wait a few minutes, I guess there is little I can do to dissuade you." It will take some time, but their behavior will begin to change once they see they cannot force you to choose guilt. Once you de-fuse the guilt, the emotional control over you and the possibility of manipulation are eliminated forever.

Do something which you know is bound to result in feelings of guilt. As you check into a hotel and a bellboy is assigned to show you to a room that you are perfectly capable of finding alone with your one small piece of luggage, announce that you'll do it alone. If you're rejected, tell your unwanted companion that he is wasting his time and energy since you will not be leaving a tip for a service that you don't want. Or take a week to be alone if you've always wanted to do so, despite the guilt-engendering protestations from other members of the family. These kinds of behavior will help you to tackle that omnipresent guilt that so many sectors of the environment are adept at helping you to choose.

The following dialogue represents a role-working exercise in a counseling group led by myself, in which a young girl (23) was confronting her mother (being played by another group member) about wanting to leave the nest. The mother was using every conceivable guilt-producing response to keep her from leaving home. This dialogue was the end product of an hour of teaching the daughter how to outmaneuver her mother's guilt-producing statements.

DAUGHTER: Mother - I'm leaving home.

MOTHER: If you do, I'll have a heart attack, you know how my heart is, and how I need you to help me with my medicine and all.

DAUGHTER: You're concerned about your health and you think you can't make it without me.

MOTHER: Of course I can't. Look, I've been good to you all these years, and now you're just walking out, leaving me here to die. If that's all you think of your mother, go ahead.

DAUGHTER: You think that because you've helped me as a child that I should repay you by staying here and not become independent and be on my own.

MOTHER: (Clutching at her chest) I'm having a tachycardia attack right now. I think I'm going to die. You're killing me, that's what you're doing.

DAUGHTER: Is there anything you'd like to say to me before you leave?

In this dialogue, the daughter refused to yield to the obvious guilt producers offered by her mother. The daughter had been a literal slave, and any effort to be on her own had always been met with guilt-engendering talk.Mama was willing to use anything to keep her daughter dependent and in her control, and her daughter either had to learn new responses or be a slave to her mother and her own guilt for the rest of her life. Take careful notice of the daughter's responses, They all begin with references to her mother as responsible for her own feelings. By saying "You feel," rather than "I feel," the potential for guilt is tactfully minimized.

Such is guilt in our culture - a convenient tool for manipulating others and a futile waste of time. Worry, the other side of the coin, is diagnostically identical to guilt, but focuses exclusively on the future and all of the terrible things that might happen.

A CLOSER LOOK AT WORRY

There in nothing to worry about! Absolutely nothing. You can spend the rest of your life, beginning right now, worrying about the future, and no amount of your worry will change a thing. Remember that worry is defined as being immobilized in the present as a result of things that are going or not going to happen in the future. You must be careful not to confuse worrying with planning for the future. If you are planning, and the present-moment activity will contribute to a more effective future, then this is not worry. It is worry only when you are in any way immobilized now about a future happening.

Just as our society fosters guilt, so it encourages worry. Once again it all begins with equating worrying with caring. If you care about someone, the message goes, they you are bound to worry about the person. Thus, you'll hear sentences like, "Of course I'm worried, it's only natural when you care about someone" or "I can't help worrying, its, because I love you." Thus, you prove your love by doing an appropriate amount of worrying at the correct time.

Worry is endemic to our culture. Almost everyone spends an inordinate amount of present moments worrying about the future. And all of it is for naught. Not one moment of worry will make things any better. In fact, worry will very likely help you to be less effective in dealing with the present. Moreover, worry has nothing to do with love which predicates a relationship in which each person has the right to be what he chooses without any necessary conditions imposed by the other.

Think of yourself as being alive in 1860, at the beginning of the Civil War. The country is mobilizing for war, and there are approximately thirty-two million people in the United States. Each of those thirty-two million folks has hundreds of things to worry about and they spend many present moments agonizing about the future. They worry about war, the price of food, the draft, the economy, all the things that you worry about today. In 1975, some 115 years later all of those worries are dead and all their combined worriers are dead and all their combined worrying did not change a moment of what is now history. The same is true of your own worry times. When the earth is populated by an entirely new crew, will any of your worry moments have made a difference? No. And, do any of your worry times make a difference today, in terms of changing the things you worry about? No, again. Then this is one zone that you must tidy up, since you are just wasting those precious present moments on behavior that has absolutely no positive payoff for you. Much of your worry concerns things over which you have no control. You can worry all you want about war, or the economy, or possible illness, but worry won't bring peace or prosperity or health. As an individual you have little control over any of those things. Moreover, the catastrophe you're worrying about frequently turns out to be less horrible in reality than it was in your imagination.

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I worked with Harold, who was forty-seven years old, for several months. He was worried about being laid off and not being able to support his family. He was a compulsive worrier. He began losing weight, was unable to sleep and was getting sick frequently. In counseling, we talked about the futility of worry and how he could choose to be content. But Harold was a true worrier, and he felt that it was his responsibility to worry about possible impending disaster every day. Finally, after months of worry, he did receive his pink slip and was unemployed for the first time in his life. Within three days, he had secured another position, one which paid more, and gave him a great deal more satisfaction. He had used his compulsiveness to find the new job. His search was rapid and relentless. And all of his worry had been useless. His family had not starved, and Harold had not collapsed. Like most worry-producing gloom pictures in one's head, the eventuality resulted in benefits, rather than horror. Harold learned firsthand the futility of worry, and he has actually begun to adopt a nonworry stance in his life.

In a clever essay on worry in The New Yorker, entitled "Look for the Rusty Lining," Ralph Schoenstein satirized worry.

What a list! Something old and something new, something cosmetic yet something triveal too, for the creative worrier must forever blend the pedestrian with the immemorial. If the sun burns out, will the Mets be able to play their entire schedule at night? If cryogenically frozen human beings are ever revived, will they have to re-register to vote? And if the little toe disappears, will field goals play a smaller part in the National Football League?*

You may be in the professional worrier classification, creating unnecessary stress and anxiety in your life as a result of the choices you are making to worry about every conceivable kind of activity. Or you may be a minor league worrier concerned only about your own personal problems. The following list represents the most common responses to the question, "What do you worry about?"

TYPICAL WORRY BEHAVIORS IN OUR CULTURE

I gathered the following data from some two hundred adults at a lecture one evening. I call this your worry sheet, and you can give yourself "worry points" similar to the "guilt points" discussed above. They are not listed in any particular sequence of frequency or importance. The parenthetical statements represent the kinds of sentences that justify the worry.

YOUR WORRY SHEET

I worry about. . . . . .

1. My Children ("Everyone worries about their children, I wouldn't be a very good parent if I didn't now would I?")

2. My Health ("If you don't worry about your health, you could die at any time!")

3. Dying ("No one wants to die. Everyone worries about death.")

4. My Job ("If you don't worry about it, you might lose it.")

5. The Economy ("Someone ought to worry about it, the President doesn't seem to care.")

6. Having a Heart Attack ("Everyone does, don't they?" "Your heart could go at any time.")

7. Security ("If you don't worry about security, you'll find yourself in the poorhouse, or on welfare.")

8. My Wife's/Husband's Happiness ("God knows I spend a lot of time worrying about him/her being happy, and they still don't appreciate it.")

9. Am I Doing the Right Thing? ("I always worry about doing things right, that way I know I'm okay.")

*Ralph Schoenstein, "Look for the Rusty Lining," The New Yorker (Feb. 3, 1975)

10. Having a Healthy Child if You're Pregnant ("Every mother-to-be worries about that.")

11. Prices ("Somebody ought to worry about them before they skyrocket out of sight.")

12. Accidents ("I always worry that my spouse or the children will have an accident. It's only natural, isn't it?")

13. What Others Will Think ("I worry about my friends not liking me.")

14. My Weight ("No one wants to be fat, so naturally I worry about not gaining back any of the wreight I lost.")

15. Money ("We never seem to have enough, and I worry that someday we'll be broke and have to go on welfare.")

16. My Car Breaking Down ("It's an old clunker and I drive it on the expressway, so of course I worry about it and what might happen if it did.")

17. My Bills ("Everyone worries about paying their bills. You wouldn't be human if you didn't worry about bills.")

18. My Parents Dying ("I don't know what I'd do if they died, it worries me sick. I worry about being alone, I don't think I could handle it.")

19. Getting into Heaven or What if There is no God ("I can't stand the idea of there being nothing.")

20. The Weather ("I plan things like a picnic and maybe it'll rain. I worry about having snow for skiing.")

21. Getting Old ("No one wants to get old, and you can't kid me, everyone worries about that one." "I don't know what I'll do when I retire and I really worry about that.")

22. Flying ("You hear about all those plane crashes.")

23. My Daughter's Virginity ("Every father who loves his daughter worries that she'll be hurt, or get into trouble.")

24. Talking in Front of Groups ("I get petrified in front of a group and I worry like crazy before I do it.")

25. When my Spouse Doesn't Call ("It seems normal to me to worry when you don't know where someone you love is, or if they're in trouble.")

26. Going into the city ("Who knows what'll happen in the jungle. I worry every time I go in." "I always worry about whether I'll get a parking space.")

And perhaps the most neurotic of all. . . .

27. Having Nothing to Worry About ("I can't just sit still when everything seems all right, I worry about not knowing what will happen next.")

This is the collective worry sheet of people in your culture. You can give worry points to each of those that seem most applicable to you, total it up, and no matter what your score it still adds up to zero. The following paragraph illustrates the extent of worry in our world. It's taken from a story in Newsday (May 3, 1975) on hospital malpractice insurance.

West Islip - Two officials of the Nassau-Suffolk Hospital Council warned yesterday that those worrying about the problems that the malpractice insurance crisis could create - if doctors cease treating patients entirely or treat only emergency cases - have not worried quite enough.

Indeed, a call to spend more time worrying about a problem. How could a story like this even appear? Because the cultural pressure is to worry, rather than to do. If all of those concerned were to worry a lot more, perhaps the problem would go away.

In order to eliminate worry it is necessary to understand the why behind it. If worry is a large part of your life, you can bet that it has many historical antecedents. But what are the payoffs? They are similar to the neurotic dividends that you receive for guilt, since both worry and guilt are self-nullifying behaviors, that vary only in a temporal sense. Guilt focuses on the past; worry on the future.

THE PSYCHOLOGICAL PAYOFFS FOR CHOOSING WORRY

Worry is a present-moment activity. Thus, by using your current life being immobilized over a future time in your life, you are able to escape the now and whatever it is in the now that threatens you. For example, I spent the summer of 1974 in Karamursel, Turkey, teaching and writing a book on counseling. My seven-year-old daughter was back in the United States with her mother. While I love writing, I also find it an intensely lonely, difficult chore which requires a great deal of self-discipline. I would sit down at my typewriter with paper in place and the margins set, and all of a sudden my thought would be back on little Tracy Lynn. What if she rides her bicycle into the street and doesn't look? I hope she's being watched at the swimming pool, because she has a tendency to be careless. Before I knew it, an hour had elapsed, and I had spent it worrying. This was all in vain of course. But, was it? As long as I could use up my present moments worrying I didn't have to struggle with the difficulty of writing. A terrific payoff indeed.

You can avoid having to take risks by using your worry as the reason for immobility. How could you possibly act if you are preoccupied with your present moment worry? "I can't do a thing, I'm just too worried about -------." This is a common lament, and one with a payoff that keeps you standing still and avoiding the risk of action.

You can label yourself as a caring person by worrying. Worry proves that you are a good parent, good spouse, or good whatever. A handsome dividend, although lacking in logical healthy thinking.

Worry is a handy justification for certain self-defeating behavior. If you're overweight, you undoubtedly eat more when you worry, hence you have a sensational reason for hanging on to the worry behavior. Similarly, you find yourself smoking more in worrisome situations, and can use the worry to avoid giving up smoking. This same neurotic reward system applies to areas including marriage, money, health and the like. The worry helps you to avoid changing. It is easier to worry about chest pains than to take the risk of finding out the truth, and then have to deal forthrightly with yourself.

Your worry keeps you from living. A worrier sits around and thinks about things, while a doer must be up and about. Worry is a clever device to keep you inactive, involved person.

Worry can bring ulcers, hypertension, cramps, tension headaches, backaches and the like. While these may not seem to be payoffs, they do result in considerable attention from others and justify much self-pity as well, and some people would rather be pitied than fulfilled.

Now that you understand the psychological support system for your worry, you can begin to devise some strategic effort for getting rid of the troublesome worry bugs that breed in this erroneous zone.

SOME STRATEGIES FOR ELIMINATING WORRY

Begin to view your present moments as times to live, rather than to obsess about the future. When you catch yourself worrying, ask yourself, "What am I avoiding now by using up this moment with worry?" Then begin to attack whatever it is you're avoiding. The best antidote to worry is action. A client of mine, formerly prone to worry, told me of a recent triumph over it. At a vacation resort he wandered into the sauna one afternoon. There he met a man who couldn't take a holiday from his worries. The other man elaborated all of the things my client should be worrying about. He mentioned the stock market, but said not to worry about short-range fluctuations. In six months there would be a virtual collapse, and that was the thing to really worry about. My client made sure of all the things he should worry about, and then left. He played a one-hour game of tennis, enjoyed a touch football game with some young children, participated with his wife in a Ping-Pong match which they thoroughly enjoyed, and finally, some three hours later, returned for a shower/sauna. His new friend was still there worrying, and began once again to chronicle more things to worry about. Meantime, my client had spent his present moments excitedly alive, while the other man had consumed his in worry. And neither man's behavior had any effect on the stock market.

Recognize the preposterousness of worry. Ask yourself over and over, "Is there anything that will ever change as a result of my worrying about it?"

Give yourself shorter and shorter periods of "worry-time." Designate ten minutes in the morning and afternoon as your worry segments. Use these periods to fret about every potential disaster you can get into the time slot. Then, using your ability to control your own thoughts, postpone any further worry until your next designated "worry-time." You'll soon see the folly of using any time in this wasteful fashion, and will eventually eliminate your worry zone completely.

Make a worry list of everything you worried about yesterday, last week and even last year. See if any of your worry did anything productive for you Assess also how many of the things you worried about ever materialized at all. You'll soon see that the worry is really a double wasteful activity. It does nothing to alter the future. And the projected catastrophe often turns out to be minor, or even a blessing when it arrives.

Just Worry! See if it is something that you can demonstrate when you are tempted to worry. That is, stop and turn to someone and say, "Watch me - I'm about to worry." They'll be confounded since you probably won't even know how to demonstrate the thing you do so well, so often.

Ask yourself this worry-eradicating question, "What's the worst thing that could happen to me (or them) and what is the likeihood of it occuring?" You'll discover the absurdity of worry in this way.

Deliberately choose to act in some manner that is in direct conflict with your usual areas of worry. If you compulsively save for the future, always worried about having enough money for another day, begin to use your money today. Be like the rich uncle who put in his will "Being of sound mind, I spent all my money while I was alive."

Begin to face the fears you possess with productive thought and behavior. A friend of mine recently spent a week on an island off the coast of Connecticut. The woman enjoys taking long walks, and soon discovered that the island was populated by many dogs who were allowed to run wild. She decided to fight her fear and worry that they might somehow bite her or even tear her limb from limb - the ultimate calamity. She carried a rock in her hand (insurance) and decided to show no sign of fear as the dogs approached. She even refused to slow down when the dogs growled and came running toward her. As the dogs charged forward and encountered someone who refused to back down, they gave up and ran away. While I am not advocating dangerous behavior, I do believe that an effective challenge to a fear or worry is the most productive way to eradicate it from your life.

These are some techniques for eliminating worry in your life. But the most effective weapon you have for wiping out worry is your own determination to banish this neurotic behavior from your life.

FINAL THOUGHTS ON WORRY AND GUILT

The present moment is the key to understanding your guilt and worry activities. Learn to live now and not waste your current moments in immobilizing thoughts about the past or future. There is no other moment to live but now, and all of your futile guilt and worry are done in the elusive now.

Lewis Carrol in Alice Through the Looking Glass talked about living in the present.

"The rule is, jam tomorrow, and jam yesterday. . but never jam today."

"It must come sometimes to "jam-today," Alice objected.

How about you? Any jam today? Since it must come sometime, how about now?