Chapter II

REVIEW OF LITERATURE

Part - A: **Theoretical Overview**

Management of Alcoholism

Ancient Indian Concepts of Stress & Stress Management

Techniques used in the Management of Stress

Alcoholic Anonymous

Part - B: **Review of Related Studies**

Stress and Alcoholism

Anxiety, Depression and Alcoholism

Management Techniques

Part - C: **Objectives and Hypothesis**
1. MANAGEMENT OF ALCOHOLISM

MODELS OF ALCOHOLISM

Alcoholism has been defined in a number of ways, each of them making assumption about the cause of the disorder and suggesting a specific course of treatment. What we view as attributes of alcoholism determines what should be studied to understand it and what should be done to treat it. Hence the investigator feels that an evaluation of various models and treatment would throw more light into the present enquiry to find out the efficacy of AA partnership and relaxation training in managing stress and maladjustment among alcoholics.

Moral model is the oldest and deep-rooted view regarding alcoholism. It holds that drinking behaviour is either due to the failure of the individual's will power or is due to the influence of an external evil force. The contemporary manifestation of this view stresses personal failure or willful sin. As per this model alcoholic is considered to be personally responsible for the problem.

Medical model holds that alcoholism is a disease, runs a fairly predictable course and has a biological origin. Jellinek (1960) is one of the most important advocates of this view. Although he considered this model as a working hypothesis, other writers treated this disease concept as the final word.

Psychologists have proposed two different models, the Psychodynamic model and the Behaviouristic model. Social learning phenomenon is viewed...
as causal factor in both these models. Psychodynamic model emphasis on emotional mental states as explanation for drinking behaviour. On the other hand, behaviourism looks to contemporary environmental contingencies. The history of reinforcement and the role of alcohol in avoiding negative emotional reaction is emphasized in this model. Social model holds that alcoholism is not evenly distributed across societies and demographic groups; and the judgment that someone is an alcoholic is made with reference to the existing social norms and standards. Social expectations play a significant role in the genesis of alcoholism. A society which permits utilitarian use of alcohol is likely to have higher rate of alcoholism compared to a society which restricts its use. Women alcoholics are less in number since they are discouraged from taking alcohol by social norms (James, 1982)

Based on the different models discussed above specific treatment programmes for alcoholism had been put forth. Some of the major classes of interventions are discussed here.

**Pharmacotherapy:**

The conception of alcoholism as a disease has fostered investigation of a large number of medicines as potential agencies for therapy. Antidipsotropics include a class of drugs that are prescribed with the aim of creating an adverse physical reaction when the person consumes alcohol. Disulfiram is the most important drug of this kind. A person taking optimum dose of Disulfiram develops and extremely unpleasant physical reaction on ingestion of alcohol due to the accumulation of acetaldehyde in the body which leads to nausea, vomiting, skin rashes and other forms of allergic reactions. Due to the possible potential
side effects, cognitive impairment and deleterious health effects, the wisdom of choosing this drug as a routine agent is being questioned recently (Miller and Hester, 1988).

Phychotropics form another group of medicines used in the treatment of alcoholism, assuming that by treating the underlying psychopathology which presumably causes excessive drinking, alcohol abuse could be controlled. Drug therapy is indeed indispensable when the alcoholic patient shows persistent psychotic features, but the volume of research does not substantiate psychotropics as primary therapeutic agent for alcoholism (Sain, 1988).

Aversion Therapy

Aversion therapies have their common goal, the altering of an individual's attraction towards alcohol. Through counter conditioning procedures, alcohol is paired with variety of unpleasant experiences. The oldest form of aversion therapy pairs alcohol with the experience of nausea induced by chemicals while the person takes his favorite drinks. Due to its lesser side effects and economy, pairing alcohol with electric shock has gained popularity recently. A terrifying type of aversion called Apnea - was practiced in 1960s. The aversive stimulus was an injection which induces paralysis for 60 seconds, and alcohol is placed on the lips of the paralyzed patient. The crude and inhuman nature of treatment raised criticism and its application was quickly discouraged. Convert sensitization which is relatively new among aversion therapies, is conducted entirely in imagination, pairing of aversive scenes with drinking imagery.
Psychotherapy and counselling

A large number of psychotherapeutic and counselling techniques have been proposed as appropriate for alcoholics. The aim of all psychotherapies and counselling is to help the patient to learn newer and relatively more adaptive ways of thinking, feeling and behaving and to relieve distress caused by their earlier maladaptive patterns. Since such an approach demands much time and self discipline, alcoholics often show reluctance to submit themselves to dynamic psychotherapy. But researches have reported that psychodynamic group therapy is effective in the management of alcoholism (Brandsma et al. 1988).

Since many of the alcoholics tend to deny or fail to recognize reality of their problem. it becomes necessary that the therapist has to confront them with the reality and persuade into treatment. But research did not support the use of an argumentative style as optimal for inspiring behavioral change. Miller (1985) put forward an alternative feedback model in which the client is given information on his current health status and is advised to reduce alcohol consumption. Another form of feedback is video tape self-confrontation (VSC) in which the client is video taped under intoxication and it is later presented before his. Confrontation in general is stressful and has potential for precipitating dropouts, negative emotional states, lowered self esteem and proximal relapse (Faia & Shean. 1976).

Alcoholism Education

An important element that has become common in alcoholism treatment centres is an educational component. Usually it consists of a series of lectures.
films, readings or discussion of the topics related to alcohol and alcoholism. Typical content includes the negative effects of alcohol on health and behaviour. In USA, drinking drivers are assigned to education programmes on hazards of drinking and driving (Malfetti, 1975).

**Marital and Family Therapy**

Alcoholics are not only problematic to themselves, but also are problematic to their family and the community as a whole. Emotional climate in the family and marital problems influence an individual’s drinking and behaviour. Hence the established patterns of family interrelationships support the disorder or undermines the cure. Ganesan (1990) has found that marital problems in the form of sexual inadequacies in the case of males may result in alcohol consumption. For them, the sexual confrontation is more threatening and drinking behaviour is used as an 'escape' mechanism. Recently therapies have increasingly included spouse and other family members in the treatment programme. Researchers have given positive findings which indicates that marital therapy is a worthwhile modality to consider for inclusion in alcoholism treatment (Corder et al. 1972, O' Farrel and Cutter, 1982).

**Controlled Drinking**

Controlled drinking is not a treatment method, but an outcome or a goal of treatment. Even when the goal of treatment has been total abstention, some of the clients have been reported to be non abstinent but have found improved. This made clinicians to start moderation oriented treatment for
Problem drinkers receiving behavioral self-control training shows marked reduction in consumption. Miller and Munoz (1982) have reported that self-directed bibliotherapy intervention based on a self help manual was as effective as therapist directed counterpart.

**Operant Methods**

Operant conditioning techniques alter behaviour through modification of its consequences. With alcoholics, reinforcement and punishment contingencies have been used to influence drinking and drinking related behaviours. Token economy has been successfully used in mental health centres for controlling undesired behaviour of both alcoholics and mental patients.

Researches were successful in increasing disulfiram compliance among methadone patients by making methadone contingent on taking disulfiram. Miller and Hester (1980) have concluded that reinforcement and punishment contingencies could be used to enhance programme compliance but ultimate impact on drinking behaviour depends on the effectiveness of the programme itself.

**Broad Spectrum Approaches**

During the last one decade, the concept of broad spectrum treatment began to be applied in the field of alcoholism. It was assumed that alcoholism is functionally related to other problems in person's life, and that an approach addressing broad spectrum of problems is more meaningful and effective than one that focuses on drinking alone. Alcoholics were often found to be deficient in social skills, this made researches to think of adding social skill training to alcoholism treatment programmes.
Community Reinforcement Approach (CRA) is another new comer in the field of de-addiction treatment regimen. It is designed to restructure the family, social and vocational climate in a manner that reinforces sobriety while discouraging further drinking by operant extinction (Hunt and Azrin, 1973). Stress is identified as a antecedent of drinking and relapses, and stress management has been evaluated as broad spectrum adjunct to alcoholism treatment. Relaxation training Viz., Jacobson's progressive relaxation and Benson's relaxation responses, different kinds of meditation and yoga find fairly useful adjuncts in any treatment programme for alcoholics (Blake, 1967).

Ancient Indian Concepts on Stress and Stress Management

Indian scholars viewed the phenomenon of stress from various perspectives ranging from stimulus oriented to responses and psychodynamic point of view. A comprehensive description of certain concepts which relate closely to the modern concepts of stress can be found in traditional texts like Charak Samhita, Yoga suthra and Bhagavat Gita. Some of these, for example, are Dukha (pain / misery) Klesa (afflictions) Kama or trisna (desires) Atman and Ahamkara (self & ego). It is interesting to note that the body - mind relationship, characteristic of modern stress studies, has been emphasized in the ancient texts of Ayurveda since very early days. The holistic ancient Indian view of stress and management of stress are obtaining currency at international levels. Rao (1983 a) very succinctly traced the origin of stress in Indian thought. The Samkhya system postulated that the feeling of dukha or stress is experienced by individual in the course of his interaction with the world around him. The system mentions three types of stress-personal (adhyatmic), situational
(adhibotic) and environmental (adhidevic). Personal stresses can be again of two types namely physiological and psychological. Physiological stresses arise from the imbalance between fundamental constituents viz., Vata, Pitta and Kabha. Psychological stresses are caused by emotional states of lust, hatred, greed, fear, jealous, and depression. The above model proposed in Yogasuthra is a comprehensive one incorporating cognitive structuring, affective and emotional stages and adaptive reactions. It also presents the concept of Kriya Yoga which is aimed at reducing the intensity of stressors and facilitates conservation of mental energy devoid of tension which is defined as Samadhibhavana (Rao, 1983 b). Ancient scholars advocate the practice of Pranayama and Dyana (meditation) for managing stress and other negative emotions.

2. TECHNIQUES USED IN THE MANAGEMENT OF STRESS

Psychologists use a number of techniques to manage the stress and negative emotions among individuals. These methods vary each other in their underlying principle. In some techniques the body relaxes first and then the message of relaxation is passed on to the mind, the reverse happens in some other techniques (Chandran, 1989).

Muscle Relaxation for Tension Release

Muscles can be relaxed either by concentrating on something relaxing or by focusing directly on a muscle with a 'relax' message. Muscles can be taught to relax (Lachman, 1983). Biofeedback is a muscle relaxation technique carried out with the help of a machine. By monitoring the muscles, the machine indicates the state of relaxation. By observing a flashing red light turning yellow and green, the client can identify a decrease in his body tension. During the
biofeedback sessions, persons can also practice relaxing his muscles by focusing on a relaxing image. *Autogenic* training is another technique often used in conjunction with biofeedback. This deep relaxation technique is developed by Schutz in 1932. The principle behind this method is that brief sessions of concentration produce an experience of relaxation. *Massage*, whether superficial or deep creates a ‘relax’ message from outside to inside. The muscle send the message to brain through neve pathways, creating a gradual sensation as the stress level abates. *Reflexology* is a concentrated message of the soles of the feet (Bergson and Tuchack, 1974). It works on the principle of acupressure, using the pressure points in the soles. Pain in organs and muscles is removed by stimulation of nerve endings which are points related to meridians. *Rofling* is a deep facial message. Usually rofling is not used for relaxing, but for getting rid of long term, conditioned tension in muscles due to physical trauma, the theory states that the release of fascia creates a relaxation in the tension of muscles (Rofl, 1977). *Bioenergics* focuses on the muscular tension of the body, a condition called by suppression of feelings. Through the use of bioenergetic exercises these tensions can be dissolved (Lowen, 1976). In *Genital muscular relaxation technique* the person attends to his genital and anal sphincter muscles, tenses them, and then relaxes them. This tensing and relaxing offers a total feeling of relaxation. Usually this technique is used in the treatment of sexual inadequacies (Ganesan, 1982).

**Jacobson's progressive relaxation** is a technique wherein one progressively relax each of the muscle groups and relaxation is attained. (Jocobson, 1938) By ‘relaxing’ means letting go of any and all contractions in the muscles.
Thus, relaxation is not an effort, it is absence of any effort. This technique has gained attention from psychologists working in different fields.

**Breathing And Meditation**

The power of breathing has been illustrated by Zen monks in Japan who are capable of reducing their oxygen consumption by as much as 20 percent. Pattern of breathing changes as one breaths more deeper and more completely. Most of the time, breathing is done shallowly. In fact, higher the stress, less regular and less deeper the breathing. The pattern to follow is to breath into the centre and exile completely. When other thoughts pass into the mind just return the thoughts to breathing. _Zazen_ technique make use of breathing pattern in bringing a relaxed response. _Pranayama_ is an ancient Indian technique similar to this.

**Praying**, for some people, acts as one of the most effective stress reducer. They experience a sense of calmness and inner peace after praying which is highly a personalized experience. Whatever may be the nature of spirituality, one may find it a source of solace at times of high stress. Certain phenomenological changes are often found reported after experiencing both relaxation exercises and meditation. The individual, experiences an improvement in his concentration and he begins to realize how everybody is alike beneath their various customs and roles. The person also feels like being nicer to people and becomes more interested in his fellow beings. The benefit is that one feels good about oneself because he feels this way towards others (Ivancivich and Matteson, 1980).
Transcendental Meditation (TM) is a form of meditation which has gained attention from both scientific and common people. Maharshi Mahesh Yogi is responsible for the introduction of this method. TM is a less complicated form of meditation and requires no particular philosophical commitment. TM uses a mantra, a single word on which one concentrates and shuts off all distractions. By chanting the mantra, one reaches a vacuum state in which both physiological and mental relaxation are at a peak. Benson (1957) who was very much a believer of TM developed an approach which hopefully duplicated the positive TM results. According to Benson, just as there is in everybody an inherent stress response, there is a relaxation response also. Developing the ability to summon forth this relaxation response is what Benson technique is all about. Instead of mantra in TM, Benson suggests the use of monosyllabic non-emotion arousing word one.

**Behaviouristic Techniques**

Among the main contributions of behaviourists are their marked empiricism and their emphasis on procedures which could be specified and measured.

Many psychosomatic patients show an inability to express their emotions due to alexithymia. Wolpe (1958) has advocated the use of Assertiveness training for management of this putative defect. This technique involves learning the expression of appropriate affect as well as assertion of one's reasonable rights. Self statement is another technique which will modify the emotional reaction and influence our conduct in stress situations. According to Meichenbaum
(1976), the things people say to themselves are important guides to behaviour. In Guided working Imagery technique, the client is taught to visualize a standard series of scenes such as, a meadow, mountain, house or a swamp. Later the patient's images are examined for sources of conflict; irrational beliefs and inter-personal conflicts (Leuner, 1969). Autogenic training is another technique, in which the patient is asked to assume an attitude of passive acceptance towards his mental experience (Luthe and Blumberger, 1977). In Covert Sensitization, the patient first imagines engaging in some behaviour which he wants to change. This is quickly followed by imagining of highly unpleasant event and therefore is less likely to occur in the future (Cautela, 1980). Covert behaviour rehearsal is the technique in which the individual systematically visualizes the desired correct coping behaviour (Mahoney, 1974).

3. ALCOHOLIC ANONYMOUS

Alcoholic Anonymous is an international fellowship of men and women who once had a drinking problem. It is non-professional, self-supporting, non-denominational, multiracial, apolitical, and available almost everywhere. There are no age or education requirement. Membership is open to anyone who wants to do something about his or her drinking problem (Alcoholic Anonymous, 1988).

What does A.A. do?

1. A.A. members share their experience with anyone seeking help with a drinking problem; they give person-to-person service or "Sponsorship" to the alcoholic coming to A. A. from any source.
2. The A.A program, set forth in their twelve Steps, offers the alcoholic a way to develop a satisfying life without alcohol.

3. This programme is discussed at A.A. group meetings.

(A) **Open speaker meeting** - open to alcoholics and non alcoholics (attendance at an open A.A. meeting is the best way to learn what A.A. is, what it does, and what it does not do.) At speaker meeting, A.A. members "tell their stories". They describe experiences with alcohol, how they came to A.A., and how their lives have changed as a result of A.A.

(b) **Open discussion meetings**- one member speaks briefly about his or her drinking experience and then leads a discussion on A.A. recovery or any drinking-related problem that anyone brings up. (Closed meetings are for A.A.s or anyone who may have a drinking problem).

(C) Closed discussion meetings - conducted just as open discussion are, for alcoholics or prospective A.A.s only.

(D) **Step meetings** (usually closed) - discussion of one the twelve Steps.

During past few years, A.A groups have welcomed many new members from treatment facilities etc. Some have come to A.A voluntarily and few others, under a degree of pressure. In the book "How A.A. Members Cooperate, it is written, "We cannot discriminate against any prospective A.A members, even if he or she comes to us under pressure from a court, an employer, or any other agency. Although the strength of the programme lies in the voluntary nature of membership in A.A., many of us first attended meetings because we were forced to, either by someone close or by inner discomfort. But continual exposure to A.A. educated us to the true nature of the illness... Who made
the referral to A.A is not what A.A is interested in. It is the problem drinker who is our concern. We cannot predict who recover, nor have we the authoring to decide how recovery should be sought by any other alcoholic."

What AA. does not do?

AA does not:

- Furnish initial motivation for alcoholics to recover.
- Solicit members
- Engage in or sponsor research.
- Keep attendance records or case histories.
- Join "councils" of social agencies.
- Follow up or try to control its members.
- Make medical or psychological diagnoses or prognoses.
- Provide nursing services, hospitalization, drugs, or any medical or psychiatric treatment.
- Offer religious services.
- Engage in education about alcohol.
- Provide housing, food clothing, jobs, money, or any other welfare or social services.
- Provide domestic or vocational counselling.
- Accept any money for its services, or any contributions from non- AA sources.
- Provide letters of reference to probe boards, lawyers, court officials.
Started by two alcoholics in 1935, AA has spread without any paid therapist or organizers at all, from drinker to drinker. The rate of growth of AA shows that an increasing number of alcoholics are recovering from this disease. There are over 73000 AA groups spread out in 114 countries. Women now constitute one third of the membership and young people about 20%. AA members who remain sober for more than a year have a very high likelihood of continuing their successful process of recovery. (Alcoholic Anonymous, 1985) Declaring scientific expertise and professional know-how, these former drinkers produce more and more dependable recoveries from problem drinking. AA has two more corollaries. A1-Anon which is a group constituting spouses of alcoholics and A1-Ateen constituting of children alcoholics.

Twelve steps of Alcoholic Anonymous

AA’s twelve steps are given below

1. We admitted we were powerless over alcohol that our lives had become unmanageable.

2. Come to believe that a power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. We are entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and become willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so should injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and mediation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

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

Twelve traditions of Alcoholic Anonymous

1. Our common welfare should come first; personal recovery depends upon AA unity.

2. For our group purpose there but one ultimate authority a loving God as. He may express Himself in our group conscience. Our leaders are but trusted servants, they do not govern.

3. The only requirement for AA membership is a desire to stop drinking.

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

6. An A.A. group ought never endorses, finance, or lend the A.A. name to any related facility or outside enterprise, that problem of money, property and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self supporting, declining outside contributions.

8. Alcoholics Anonymous should remain forever nonprofessional, but our service centres may employ special workers.

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

10. Alcoholic Anonymous has no opinion on outside issues; hence AA name ought never be drawn into public controversy.

11. Our public relation policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.

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

No other system of helping alcoholics has such a wide spread network of information system. It therefore exerts a forceful influence on alcoholism treatment and research a beyond its professionally narrow range of interest.
Part - B: REVIEW OF RELATED STUDIES

Stress and Alcoholism

Anxiety, Depression and Alcoholism

Management Techniques
Stress and Alcoholism

Camatta and Nagoshi (1995), found that impulsivity and venturesomeness were more significantly correlated with quantity and frequency of alcohol use, but not with occurrence of alcohol use problems. Depression, stress and irrational beliefs were significantly correlated with alcohol related problems; but not with alcohol use. Further analysis revealed that effect of stress on alcohol problems was mediated by depression whereas the effect of depression in turn was mediated by irrational beliefs.

Extent of Brain damage and related emotional changes in drug addiction was the area of study for Sahni and Bhargava (1990). They reported that psychoactive substances affect a person's mood, feeling, thinking and behaviour and may produce altered states of consciousness. In times of turmoil and stress, drugs are often used as a means of alleviating anxiety and for coping with problems. Many drug problems today result from use and misuse of multiple drugs that can interact to produce a variety of drastic effects including brain damage and death. Findings of the study indicated that significant difference exist between drug addicts and new addicts on Bender Visual Motor gestalt test scores. The authors attempted to explain the personality variance seen among alcoholics in terms of brain dysfunction.

An experiment was conducted by Hull and Young (1983) to test the proposition that alcohol is consumed as a function of the quality of past performance and the individual's level of private self consciousness. As predicted, high self conscious subjects who has received failure feed back drank significantly
more wine than did high self-conscious subjects who received success feedback. Consumption by low self-conscious subjects fell between these extremes and did not vary as a function of success or failure. In addition, the data indicated that these results were mediated by differential sensitivity to the implications of success and failures by high and low self-conscious subjects. The results are discussed in terms of their implications for theoretical accounts of the psychological antecedents of alcohol consumption. But further studies didn't totally agree to these findings.

Chassin et al. (1988) conducted a study to evaluate Hull’s theory (1983) suggesting that alcohol use may be motivated by a desire to avoid painful states of self awareness. The findings did not support the earlier predictions of self awareness. Goreman and Peters (1990) analysed those life events occurred in the year before the onset of alcohol dependence in 23 patients. Results showed that individuals may enter the initial stages of alcohol dependence in response to stressful life events.

Stewart (1996), in a critical review of literature on alcoholism and exposure to trauma, has observed a strong relationship that exists between exposure to traumatic events and alcohol problems. The relationship is reported to be more concrete between diagnosis of post traumatic stress disorder (PTSD) and alcoholism. Brislin et al. (1995) proposed a model of stress and alcohol use that includes coping preference as an important moderator of women's drinking. The result of the study was consistent with the notion that stress could influence alcohol consumption.
Altonen and Makel (1994) attempted to understand how male and female alcoholics describe their drinking problems and reported that “the drinking man is threatened by feeling of inferiority, the drinking women by shame and guilt”. Dumka and Rossa (1995) conducted a study to find out the role of stress and family relations in mediating problem drinking and father's personal adjustment. Father's problem drinking was found contributing to family stress and father's diminished personal adjustment. Family stress was found related to reduced marital adjustment and personal adjustment. Dunn et al. (1987) reported that a causal relationship exists between alcohol and marital stress.

Crowe and George (1989) has reviewed the vast literature investigating the relationship between alcohol and human sexuality and concluded that (a) alcohol disinhibits psychological sexual arousal and suppresses physiological responding (b) distribution is both pharmacological and psychological (c) expectancies and cognitive impairment can disinhibit separately or jointly.

Kline (1990) made an attempt to contemplate the relationship between the beliefs about the behavioural effects of alcohol and pattern of alcohol use. Beliefs that alcohol enhances sexuality, reduces stress, improves sociability and elevates mood were found to be the best predictors of multiple negative drinking related consequences.

Historically wives of alcoholics have been described as having disturbing, pathological personalities that are instrumental in causing and maintaining their husband's drinking.
Kogan et al. (1968) reported that wives of alcoholics exhibit more generalized personality distress. Denikar et al. (1964) found that most common traits of wives of alcoholics were dependency, frigidity and other manifestations of neuroticism. Several studies have reported high neurotism among wives of alcoholics (Chakravarthy and Ranganathan, 1985, Kodandaram 1993). Montgomery and Johnson (1992) reported that (a) the behaviour of wives of alcoholics reflects their stressful circumstances. (B) the women in the study reported interpersonal, extrapersonal and intrapersonal stressors; the most frequently reported and highest ranked stressor was their relationship with their husbands. (c) sobriety doesn't necessarily mean that stressors disappear.

A recent investigation undertaken by Kalarani et al. (1997) attempted to identify the contribution of the husband's alcoholism on the spouse's stress proneness. Wives of chronic alcoholics, occasional drinkers and new drinkers were compared and results showed that spouse's stress proneness is directly related to the severity of husband's drinking.

Limited research has examined the relationship between financial strain and alcohol use. Peirce et al. (1994) reported that the affect regulation model of financial strain and alcohol use was found existing. Generally, depression mediates the relationship between financial strain and drinking to cope, and drinking to cope mediates the relationship between depression and alcohol use. In addition, both gender and race moderate the relationships.

Peirce et al. (1996) examined whether specific facts of social support moderates the relationship between stress and alcohol involvement. Results supported the buffering influence of tangible support on stress-alcohol involvement relationship.
Boxer and Wild (1993) studied the psychological distress and alcohol consumption among the fire fighters. The findings reveal that 41% of fire fighters experience significant distress which is higher than expected in a typical community of working population. Positive relations were observed between alcohol consumption and the 10 most highly ranked work stressors. Crum et al. (1995) conducted a longitudinal study on 571 subjects which supported the earlier proposition that occupational stress is significantly related to risk of alcohol dependence.

Johnson (1994) in a study among Indian population in America, identified certain problems faced by Indians which are multifaceted and interacting. They bear directly on the community and individual's self-esteem. The four major points of these problems are stress, depression, alcohol/drug dependence and racism.

Levenson et al. (1987) studied, the effects of high dose of alcohol on physiological and self-report responses on two stressors (electric shock and self disclosing speech) were compared with the effects of a placebo in three groups of non alcoholic subjects, considered to be at heightened risk for alcoholism by virtue of their (a) having an alcoholic parent (parental risk) or (b) matching a free alcoholic personality profile. These high risk groups were tested with appropriate controls for drinking experience. For female subjects, phase of menstrual cycle was also considered. Results indicated that positively reinforcing effect of alcohol (its capacity to attenuate physiological responses to stress) was more pronounced in high risk group than in low risk group. This relations were found for both parental risk and personality risk factors and in both male and female subjects.
Pehorecky (1991) had reviewed last 10 years' literature on stress and alcoholism. The review covered selected aspects of the interaction of alcohol and stress. Important findings are presented below:- (1) Most of the review focused on the role of stress on alcohol ingestion. Retrospective research based on data from the health and nutrition examination definitely indicated an increase in alcohol consumption with anxiety in certain groups of, as yet not well characterized, individuals. For example, although still insufficiently documented, stress does not appear to play a significant role in alcohol ingestion by women and the elderly. By contrast, stress does appear to play a role in the control of alcohol ingestion by adolescents. Prospective studies employing questionnaire-interview formats generally support an effect of stress on alcohol ingestion. However, studies employing male college aged social drinkers did not find a correlation between levels of stress and ingestion of alcohol. Alcoholics also differ in the reasons for drinking alcohol, but generally ingest alcohol to lessen anxiety/stress. It is clear that the Tension Reduction Hypothesis alone as originally postulated is no longer adequate. Many new models based on an interaction of alcohol and stress have been proposed to explain the control of alcohol consumption. Considering the control of alcohol ingestion, it is unlikely that a single model could possibly be a relevant model to alcohol consumption under specific conditions, or for specific populations. (2) Alcohol has been reported to decrease anxiety in agoraphobic. The self-medication by agoraphobic may contribute significantly to their alcohol abuse. (3) Alcohol has also been reported to decrease tremor of the hands in stressed subjects as well as in patients with essential tremor. (4) Although a number of studies have employed electrodermal activity to understand the interaction of alcohol...
and stress, the results have been rather inconsistent. (5) The controversy on the reported beneficial effect of alcohol on the cardiovascular system persists. A number of studies have shown a J or U shaped relationship between alcohol and stress induced coronary heart disease. Alcohol may also influence stress-induced changes in blood pressure in individuals ingesting less than two drinks per day compared with abstainers of heavy alcohol imbibes, the evidence is not conclusive. (6) it is not clear whether the interaction of alcohol and stress involves alternation in plasma catecholamines.

**Anxiety, Depression and Alcoholism**

According to Wesner (1990) researchers interested in the treatment of substance abuse should become acutely interested in the recognition and treatment of quality disorder in their parents. Identifying parents with anxiety disorders would be the first step in individualizing treatment for a given alcoholic patient. Pollard et al. (1990) reported that there is an unusually high prevalence of panic attacks among alcoholics.

Schweiger (1996) has reported that alcohol and related problems are directly related to early childhood anxiety disorders. Jensen et al. (1990) reported that anxious alcoholics, run the risk of abusing anxiolytics, opiates and sedatives than non anxious alcoholic patients. Mc Cusker (1991) studied the cue-responsivity in dependent drinkers with personality vulnerability and anxiety as intervening variables. It was found that cue-responsivity elicited increases with self reported anxiety. The study raised the interesting possibility that a personality disposition akin to trait anxiety, and the degree to which cue exposure elicits state anxiety, mediated the relationship between cue responsivity and craving in dependent drinkers.
Kushner et al. (1994) evaluated whether alcohol outcome expectancies moderate the association between measures of anxiety and alcohol use. Student subjects completed questionnaire related to their level of anxiety, recent alcohol use patterns and outcome expectations to be tension reducing. Consistent with predictions, male Ss with tension reduction alcohol outcome expectancies showed a positive correlation between measures of anxiety and drinking behaviour than did male subject with low tension reduction outcome expectancies. The result of the study supports the Tension Reduction Hypothesis of stress induced drinking.

Brown et al. (1991) conducted a study to explore the change in anxiety among abstinent male alcoholics. Results indicated that recently detoxified patients experience multiple anxiety symptoms. By the second week anxiety returned to normal range and symptoms started decreasing. Elevated levels of anxiety symptoms were more common for patients with history of panic episodes or anxiety disorder. Relapsers scored higher on anxiety when compared to abstainers in the follow-up.

Blockland et al. (1992) studied the effect of alcohol on anxiety in rats. 12 three months old rats were given 20% ethanol solution for 6 months as the only source of liquid; and the control group receiving tap water. 3 weeks after the cessation of treatment both groups were assessed on level of anxiety. It was found that anxiety was significantly less in ethanol treated rats.

Keller (1995) reported that there was no significant difference between the age of onset of addiction or choice of drug between primary and secondary anxiety patients. Allan (1995) has questioned the assumption that anxiety reduction is a major factor in the etiology of problem drinking. There are many
studies which document the occurrence of anxiety symptoms in the problem drinkers. But the difficulty lies in deciding which comes first: the alcohol problems or the anxiety. Anxiety can be a consequence rather than a cause of heavy drinking.

Hallen (1996) conducted an experiment to study the adaptation to repeated restraint stress in rats treated with alcohol. Findings showed inability of ethanol treated rats to adapt in the stress schedule compared to the control. Results imply that excessive alcohol consumption may impair adaptation to stress and thus conceivably precipitate depression.

Brennan et al. (1994) conducted a longitudinal analysis of the late life problem drinkers on personal and environmental risk factors as predictors of alcohol use, depression and treatment seeking. Study concluded that personal risk factors such as prior function, male unmarried, early onset of drinking and avoidance coping are independently predictive of poor outcomes. Among environmental risk factors, negative life events, chronic health, spouse stressors and having more friends who approved of drinking were independent predictors of poorer follow-up functioning and treatment seeking. Interaction between personal and environmental risk factors helped to predict subsequent alcohol consumption and treatment seeking.

Maharaj (1990) investigated the relationship between alcoholism, depression, life events, stress, and purpose in life. Thirty-five first admission alcoholics and an equal number of Alcoholic Anonymous members were assessed on alcoholism, depression, stress and purpose in life using objective measures. The results indicated significant differences between the two groups on drinking
behaviour, depression and purpose in life. However, no difference was noted between groups on stress. Positive correlation was obtained between drinking behaviour and depression, life events and purpose in life.

McGann (1990) reported significantly higher prevalence rates of depression and obesity among family members of alcoholics compared to that of non alcoholics. Windele and Biller (1990) reported that depression was significantly associated with problem drinking. Akerlind and Hornquist (1990) in a detailed evaluation of 78 alcoholics, concluded that change in loneliness was accompanied by change in well-being, mood related psychiatric variables and satisfaction with autonomy and life as a whole.

Benishek et al. (1992) explored the relationship between global psychopathology, depression, anxiety and alcoholism treatment outcome among males and females. It was found that psychopathology, particularly anxiety and depression differentially affects the substance abuse treatment response of men and women.

Management techniques.

Different therapeutic techniques have claimed their efficacy in managing alcoholism. But we are still not sure as to (a) what treatment methods are most effective (b) How to match a particular individual for a specific technique (c) How is the effectiveness influenced by length, intensity and settings of treatment.

Aversion therapy was the most widely used techniques in the past. Kishore and Dutt (1986) conducted a study with sixty patients in two groups. One group
was given electric aversion therapy and other group was given psychotherapy in addition to aversion therapy. Results indicated that both groups showed remarkable abstinence and improvement. Smith and Frawley (1991) has reported that a multimodel alcoholism treatment program utilizing aversion therapy was at least as acceptable to patients as counsellee centered programmes, and can be expected to give increased abstinence rates. Chakravarthy and Mishra (1990) studied the efficacy of aversion therapy in the management of alcoholism using faradic aversion therapy and covert sensitization. Significant improvement was noted at the end of the treatment. Aversion therapy was experimentally evaluated in the context of alcoholism treatment and was found that it was not more effective than placebo in controlling drinking habit (Miller et al. 1973; Hedberg & Campbell, 1974; Wilson et al, 1975). Wilson (1978) has questioned the empirical justification for continued use of aversion therapy as a treatment alternative.

Since different aversion agents like electric shock, and emetics produce unwanted side effects, Ganesan (1985) pioneered the use of alcohol itself as an aversive agent against problem drinking.

The application of psychotherapeutic techniques in the management of alcoholism has attained currency from researchers and clinicians. Therapeutic approaches including psychoanalysis, T.A, family therapy, confrontation and counselling, group therapy etc are widely used. The efficacy of these techniques are generally accepted. (Wallagren and Barry, 1970; Nietzel et al. 1977, Rachman and Wilson 1980; Saunders, 1990). Sobell and Sobell (1973) conducted a major outcomes study comprising behavioural approaches with hospital treatment.
alone in groups having either an abstinence or a moderation goal. Within the controlled drinking goal, patients receiving the behavioural treatment were reported to show superior outcome as compared with control subjects at follow-ups ranging to 3 years.

Drummond and Glaütier (1994) evaluated the effectiveness of cue exposure treatment (CE) in alcoholic dependence. 35 men who were detoxified and purely alcohol dependent received either cue exposure or relaxation control (RC) treatment. CE subjects had 40 minutes exposure to the sight and smell of preferred drink. RC subjects were given relaxation therapy. In a 6 months follow-up, it was found that CE subjects came out with significantly favourable results in terms of latency to relapse and total alcohol consumption. The result pointed out to the importance of cue exposure as a treatment for addictive behaviour.

Botwin et al. (1990) observed a significant prevention effect in the alcohol and other drug use through a multimodel cognitive behavioural approach. Saunders (1990) in an exhaustive review found that the efficacy of cognitive behavioural strategies is well documented in the short term and cue exposure response prevention offers promise. It has been theorized that respondent conditioning in past and underlying desire for alcohol contribute to relapse. One implication of this theory is that relevant conditional responses could lie eliminated by respondent extinction. However, it is also noted that smell of alcohol is not always sufficient to elicit desire for alcohol. In view of this, it has been suggested that introspective cues such as mood states are also important. Extensive studies conducted by Litt et al. (1990) showed that (a)
exposure to alcohol cues had no effect on desire for alcohol when subject was in relaxed and neutral mood, (b) negative mood states alone can produce desire for alcohol, regardless whether alcohol was presented or not. The study suggests that reactivity to alcohol cues may be substantially reduced by relaxation.

The efficacy of bio feedback therapy on sobriety outcome in alcoholism treatment was studied by Denney et al. (1991). The results showed that the frequency of sobriety for those patients with at least 6 sessions was significantly better than those with less or no training. The effect was most prominent with those receiving the highest level of bio-feedback training. Black (1967) found that 12 months improvement rate with electrical aversion (50%) could be improved (59%) by addition of relaxation training.

A study to compare the differential efficacy of anxiety management and relaxation training with respect to their impact on anxiety levels and alcohol consumption among people attending an alcohol treatment unit was undertaken by Ormord and Budd (1991). It was hypothesized that anxiety management would have a greater effect on outcome measures than could relaxation training. The two treatment groups were found to be significantly low on anxiety. Anxiety management was found most effective, however, both had no impact on alcohol consumption.

Alcoholic Anonymous (AA) is another technique in which alcoholics learn themselves, to abstain from alcohol. It is found effective in the management of chronic alcoholic, since AA takes into account the rehabilitation and resocialization aspect in deaddiction therapy (Saunders, 1990). Researchers
have poured praise on AA and its activities from time to time. Fox and Lyon (1955) called AA “remarkable success”, a “shining example” and so on. Beldon (1962) wrote that it has been well established that many alcoholics benefit most from joining the AA. Hayman (1956) after polling psychiatrists, has reported that 99% of his respondents approved of AA and 97% has referred patients to it. Of patients, they know in AA, 40% has been abstinent upto one year. Stone (1962) wrote “it seems generally argued the most successful therapeutic treatment for alcoholism has been formulated and established by AA. Black (1962) called AA “Wonderful and inspiring,”. In professional literature, AA has been described as an adjunct to other alcoholism treatment programmes (Chwelos et al. 1959, Robson et al. 1965).

Strayer (1961) reported that 29 patients in prolonged group therapy did better after some what disassociating themselves from AA. Mc Ginnis (1963) found that those patients exposed to professionally directed group therapy grew far in ego strength than those imposed to AA. Haertzen et al (1968) reported after using personality, habit and attitude tests that membership in AA was “non significant” in their sample of hospitalized alcoholics.

In spite of criticism raised against AA reports for lack of methodological sophistication. Leach (1969) after an exhaustive review of AA studies,, concluded that “AA really does work”

McPeake et al. (1991) held the view that attaining altered states of consciousness is a human motive. The substance dependent population pursue
these states destructively by inappropriate use of alcohol and drugs. Despite a body of available literature, the alcohol and drug treatment programmes fail to address this motive due to lack of social approval, means-end confusion and lack of trained professionals. On the other hand Alcoholic Anonymous directs its members towards an altered state of consciousness called spiritual awakening. Failure to address the patient's need for attaining altered states of consciousness can account for a part of relapses. At the Back Hill hospital, New Hampshire, the authors had introduced Altered State of Consciousness Therapy (ASCT) programme in which patients were taught to consciously manipulate affect and cognition to achieve a new consciousness.

Denney and Baugh (1992) studied the relationship between subjective symptom reduction and sobriety on a large sample of male alcoholics who had completed an inpatient alcoholism treatment which included biofeedback or relaxation sessions. Specific symptom reflect for anxiety was significantly correlated with sobriety. In addition, the reduction of symptoms showed a positive trend with sobriety. Chaney et al. (1978) reported that relaxation techniques not only improved interpersonal functioning but also resulted in sequentially reduced alcohol intake in one year follow up.

Mac Nab et al. (1989) determined the family involvement in the treatment of alcoholism. The study observed strong association between greater family involvement and abstinence; later family relationship and positive feelings about self. Zavjalov (1991) proposed Clinical psychological approach to alcoholism and related problem in which the patient and his views and opinion were of
prime importance. Collins et al. (1991) pointed out that a structured outpatient treatment programme is safe and effective in alcoholism since it obviate the need for many patients to be admitted as inpatients.

Objectives of the study

The central theme of present investigation is to study the management of stress and maladjustment among alcoholics. On the basis of available literature and discussions with experts in this field, following objectives were formulated before starting the study.

1. To find out the stress and maladjustment among alcoholics.

2. To find out the efficacy of AA group membership on the management of stress and maladjustment among alcoholics.

3. To find out the efficacy of relaxation training on the management of stress and maladjustment among alcoholics.

4. To find out the difference of efficacy between AA group membership and relaxation training in management of stress and maladjustment among alcoholics.

5. To find out the rate of relapse among alcoholics who attend AA meeting and those who practice relaxation.

Considering the above mentioned objectives, the following hypotheses were formulated.
Hypotheses

H_1: 1 There will be significant difference among Exp. gr. 1 (attending AA meetings), Exp. gr 2 (practicing relaxation), and the control group on Stress over a period of 3 years.

H_1: 2 There will be significant difference among Exp. gr. 1 (attending AA meetings), Exp. gr 2 (practicing relaxation), and the control group on Anxiety over a period of 3 years.

H_1: 3 There will be significant difference among Exp. gr. 1 (attending AA meetings), Exp. gr 2 (practicing relaxation), and the control group on Depression over a period of 3 years.

H_1: 4 There will be significant difference among Exp. gr. 1 (attending AA meetings), Exp. gr 2 (practicing relaxation), and the control group on Inferiority over a period of 3 years.

H_1: 5 There will be significant difference among Exp. gr. 1 (attending AA meetings), Exp. gr 2 (practicing relaxation), and the control group on Mania over a period of 3 years.

H_1: 6 There will be significant difference among Exp. gr. 1 (attending AA meetings), Exp. gr 2 (practicing relaxation), and the control group on Paranoia over a period of 3 years.

H_1: 7 There will be significant difference among Exp. gr. 1 (attending AA meetings), Exp. gr 2 (practicing relaxation), and the control group on General Maladjustment over a period of 3 years.

H_1: 8 There will be significant difference among Exp. gr. 1 (attending AA meetings), Exp. gr 2 (practicing relaxation), and the control group on Rate of relapse to alcohol over a period of 3 years.