CHAPTER - 1

INTRODUCTION

From time immemorial history has accounted of man’s behaviour of consuming substances that intoxicated him. From centuries past taking of substances producing intoxication has been valued high in some societies. Continued practice of taking drugs has been invited and appreciated for various social reasons. History has also recorded that the practice of social drinking has lead many to get addicted to it. Hence a lot of literature has evidenced alcoholism and the related problems. The nature and impact of alcoholic addiction, and the related problems have been conceived and viewed differently by philosophers, and scholars. Different methods and measures have been adopted to overcome the problems of drinking. Though extensive concentration is given over the treatment of alcoholics, the success achieved in making them abstain from alcohol is relatively low. Hence research in the realm of treatment of alcoholism is continuing, as new problems and the precipitating factors keep emerging.

1.1 ADDICTION TO ALCOHOL

It has long been recognized that tension, stresses, anxiety and related physical and psychological states are frequently unpleasant or painful for many individuals. Much of one’s behaviour is motivated by the need to eliminate or reduce those sensations and feelings (Selye, 1976). Taking alcohol is one such activity by which an individual tries to reduce the feelings of unpleasantness.
relaxation and tension reduction than did light or moderate drinkers (Brown et al. 1985). Thus the expectation of tension reduction may play a role in the development of excessive drinking patterns and the perpetuation of alcohol abuse. This is the stage called addiction to alcohol or alcoholism.

When an individual is addicted to alcohol his drinking interferes seriously with his physical and mental health, his marital or family life and his work. Addiction to alcoholism may happen any time from early childhood through old age, though it appears to occur most commonly during early and middle adulthood.

Alcoholism has been reported to develop during periods of crisis or following significant life events that have led to serious instability, confusion and role stress (Coleman, 1972). Other instances of stress include marital disharmony, unemployment and death of a relative. It is suggested that during such periods of heightened stress an individual's normal coping mechanisms are overwhelmed and he or she resorts to more extreme means of easing the stress including in some cases heavy consumption of alcohol.

The common experiences faced by an alcoholic is confusion, negative feelings and assorted coping devices (Jellinek 1960). To many alcoholics, happy memories of boisterous good times from early drinking experiences and recall periods of normal social drinking that did not have unpleasant effects results in confusion since incongruity between images from the past and present misery. The unfounded hope that if one searches hard and long enough, one can find a way to control and enjoy drinking indicates search for magic. The negative
feelings that an alcoholic experiences range from remorse, guilt, shame, and self-hatred to depression and feelings of helplessness, futility, loneliness and alienation. Ironically many of the feelings are augmented by alcohol (Jellinek 1960).

An alcoholic develops elaborate defense mechanisms or coping devices to escape from these feelings. For example, rationalization is used to find a reason why one should have a drink to relax, to go to sleep, to avoid offending someone, to celebrate, and so on. Another device is projection of blame onto the spouse, the boss, the parents, the police, or the system. This draws others into the delusional system of the alcoholic and often becomes the excuse for drinking. Denial, like rationalization, allows the alcoholic to kid him or herself into believing that no problem exists. Such denial is often reinforced by others refusing to accept that a loved one, co-worker, or friend may have a serious drinking problem. Even professionals are often involved in the denial system.

1.2 DEFINITION AND DIAGNOSTIC CRITERIA

Alcoholism is defined as 'alcohol dependence syndrome' by the world health organization. Alcoholism is characterized, by a compulsion to imbibe alcohol on a continuous or periodical basis, to experience, its psychological and physical effects and some times to avoid the discomfort of its absence (Chunkapura, 1988).

According to the W.H.O "alcoholics are those excessive drinkers whose dependence on alcohol has attained such a degree that it shows a noticeable
(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

The symptoms have never met the criteria for Substance Dependence for this class of substance.

The Substance Dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following, occurring at any time in the same 12-month period:

(1) Tolerance, as defined by either of the following:

(a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect.

(b) Markedly diminished effect with continued use of the same amount of the substance.
Withdrawal, as manifested by either of the following:

(a) The characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances).

(b) The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

The substance is often taken in larger amounts or over a longer period than was intended.

There is a persistent desire or unsuccessful efforts to cut down or control substance use.

A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.

Important social, occupational, or recreational activities are given up or reduced because of substance use.

The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).
Diagnostic Criteria for Alcohol Intoxication

A. Recent ingestion of alcohol.

B. Clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, impaired judgment, impaired social or occupational functioning) that developed during, or shortly after, alcohol ingestion.

C. One or more of the following signs, developing during, or shortly after, alcohol use:

   (1) Slurred speech
   (2) Incoordination
   (3) Unsteady gait
   (4) Nystagmus
   (5) Impairment in attention or memory
   (6) Stupor or coma

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Diagnostic Criteria for Alcohol Withdrawal

A. Cessation of or reduction in alcohol use that has been heavy and prolonged.
B. Two or more of the following, developing within several hours to a few days after Criterion A:

(1) Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100).

(2) Increased hand tremor

(3) Insomnia

(4) Nausea or vomiting

(5) Transient visual, tactile, or auditory hallucinations or illusions

(6) Psychomotor agitation

(7) Anxiety

(8) Grand mal seizures

C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.
Jellinek (1960) has identified various types of alcoholics. He described it as: Alpha, Beta, Gamma, Delta and Epsilon.

Alpha- This is purely a psychological dependence on alcohol that is marked by poor frustration tolerance or inability to cope with tensions. Alcohol is used to boost morale, block out reality, bolster self-confidence, or relieve emotional or bodily pains.

Beta- This is a social dependence on alcohol, without either psychological or physical dependence. The cause of drinking is largely socio-cultural or situational and is common in occupations where "everybody" get drunk every weekend.

Gamma- This is the chronic, progressive type of alcoholism. Psychological dependence progresses to physical dependence. Control over how much one drinks is lost, and a person's tolerance to alcohol is increased.

Delta- This is often called the "maintenance drinker", the alcoholic who has lost control over when rather than how much he or she drinks. Inability to abstain, rather than inability to stop once they start, is the characteristic. Increased tolerance and severe withdrawal symptoms like delirium tremens are common.

Epsilon- This is the periodic or binge drinker who abstains without difficulty for long periods but, once started, drinks heavily until passing out. He may experience no cracking or struggle to maintain sobriety and may keep liquor
at home without being tempted to indulge. The physical and psychological dependence leads to a loss of control and possibly more severe organic damage than the previous four types.

Over a long period of time, the consistently heavy drinker becomes physically and psychologically dependent on alcohol (TTRCRF, 1989).

**Physical dependence**

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

**Psychological dependence**

Psychological dependence is present when alcohol becomes so central to a person’s thoughts, feelings and actions (morbid preoccupation) that it is almost impossible for him to stop using it. This form of dependence refers to a craving for the psychological effects. For those who have developed psychological dependence, even a temporary non-availability of alcohol tends to produce anxiety and feelings of panic.

The relationship between alcoholism and physiological, psychological functions are discussed in the following sections.
The statement numbers of key to the diagram.

1. Alcohol is taken into the body through the mouth and travels to the stomach via the esophagus. Alcohol, in its initial state, is in a form which can be immediately used by the body.

2. In the stomach, chemicals are added to the alcohol. These chemicals have little effect on the alcohol. Much of the alcohol is absorbed into the bloodstream directly from the stomach.

3. The remaining alcohol travels to the small intestine where it is absorbed into the blood.

4. Once in the bloodstream, the alcohol travels to all parts of the body. It affects heart rate, blood pressure, appetite, gastric secretion, urine output, etc.

5. Alcohol also affects the brain, causing a variety of reactions ranging from relaxation to unconsciousness and death.

6. In the liver, the chemical alcohol undergoes the process of oxidation, where it is eventually changed to carbon dioxide, water and a release of energy. These chemicals re-enter the bloodstream and move on to the kidneys.

7. The kidneys filter out the end products of the oxidation process, which are finally excreted out of the body.
8. About 95-98% of the alcohol undergoes steps 1-7; however, the remaining 2-5% escapes unchanged via sweat, the breath and the urine.

Alcohol is one of the few things that is absorbed as soon as it enters the stomach. Its molecules are small and its chemical pattern simple enough to be used for fuel almost immediately after swallowing. Unlike other food, alcohol does not need digestion. After ingestion, it is carried to the stomach and small intestines and immediately gets across through the wall of the stomach into the bloodstream, from where it is carried to almost all the organs. The rate of absorption is not constant, but depends on various factors like the speed of drinking, concentration of alcohol taken, the amount of foodstuff in the stomach, etc. In the liver, alcohol undergoes a process of oxidation whereby it is changed into carbon dioxide and water and finally energy is released.

**Short-term effects**

These effects appear rapidly even after small or large doses and is appear within a few hours. Alcohol affects the brain and nerve cells, which in turn affect human behaviour. The brain is highly sensitive even to very low alcohol concentrations. The disturbances which result are shown in the activities of the organs controlled by the brain. A peculiar characteristic of alcohol is that all the nerve cells in the brain are not affected by the same BAC (blood alcohol concentration). Some nerve centres are more resistant than others, and not affected by low BAC. For example, the first to be affected are the centres controlling the higher functions that have been learnt. These include inhibitions and judgement. It is always important to remember that the degree to which
people are affected is not always reflected in their behaviour. Since people react differently to alcohol, there is no way telling by outward behaviour as to how much of alcohol a person has consumed. It can only be approximately generalized.

EFFECTS OF ALCOHOL ON AREAS OF THE BRAIN

BRAIN

Key For Brain Diagram

- One to two drinks.
- Three to four drinks.
- Five to seven drinks.
- Eight to twelve drinks.
from these, emotions are instable i.e., tension and anxiety is increased, and poor interpersonal relationship exists (Rosenberg 1969). Because of withdrawal symptoms stress is increased and it leads to psychophysiological problems. Personality deterioration leads to abnormal symptoms or deviant behaviour, cognitive dysfunction's and occupational inefficiency.

1.4.1 Emotional Stability and Alcoholism

Emotionality is defined at the psychological level as a susceptibility to become easily and intensely distressed (Buss & Plomin, 1975). At the physiological level it can be defined as excessive autonomic lability. A high degree of association exists between physiological lability and psychological instability (Eysenck, 1983) Sieber & Bentler (1982), studied 750, nineteen year old man and re-tested them when they were 22 years old. They found that excitability, dominance and aggressiveness were directly related to subsequent substance misuse.

Rosenberg (1969), found that alcoholics under 30 years of age scored higher on the EPI Neuroticism scale than alcoholics over 30 years of age, which led the author to conclude that young alcoholics have abnormally high levels of anxiety that they are unable to control or release in a suitably adaptive fashion. The finding that the young alcoholics, without a long-standing history of alcohol misuse, exhibited more Neuroticism, combined with the finding that their scores were higher than those of older alcoholics.
It suggests that the psychological and inferred physiological liability either predate the onset of problematic drinking or develops soon thereafter. Evidence that these disturbances predate the onset of alcoholism was presented by Gomberg (1982), who observed that young alcoholics (30 years of age or under that) showed numerous behavioural disturbances in childhood that were indicative of neurotic propensities. These features included nail biting, shyness, nightmares, phobias, tantrums, tics, stuttering, thumb sucking and eating problems.

1.4.2 Psychophysiological symptoms and Alcoholism

The psychophysiological disorders or symptoms are based upon four major factors, (1) Constitutional sensitivity of the autonomic nervous system, (2) Learning in the form of conditioning (3) The symbolic meaning of a particular organ system and (4) The presence of a stress situation. The psychophysiological symptoms are frequently seen in connection with stress situations (Kischer, 1972). Social, cultural, and familial factors may also operate by increasing or aggravating conditions of environmental stress that provoke or precipitate episodes of alcohol abuse (Bales, 1946).

The psychophysiological disorders are ordinarily classified on the basis of the body system through which the symptoms are expressed. The more common psychophysiological disorders are (1) Cardiovascular reactions, (2) Gastrointestinal reactions, (3) Respiratory reactions, (4) Skin reactions, (5) Genito Urinary reactions (Kischer, 1972). According to Keller and Effron,
Alcoholism is a chronic illness, psychic, somatic or psychosomatic, which manifests itself as a disorder of behaviour.

1. Alcohol and Cardiovascular Reactions:

   Alcohol is a vaso-dilator which dilates the blood vessels. It increases the heart rate and output of blood in circulation. Excessive alcohol use weakens the heart muscle and leads to cardiomyopathy.

2. Alcohol and Gastro-Intestinal System:

   In low concentrations, alcohol increases gastric secretion and hence acts as an appetizer. Heavy alcohol ingestion leads to erosive gastritis or inflammation of the mucosal lining of the stomach. Gastritis occurs due to the two-fold action of alcohol, namely increasing gastric acid production and increasing the permeability of the mucosal cells to back-diffusion of gastric acid.

3. Alcohol and Respiratory Reaction:

   Alcohol depresses the respiratory center in the brain. In cases of high doses of alcohol intake, death could result from respiratory failure.

4. Alcohol and Skin Reaction:

   The skin disorders in alcoholics are a result of vitamin deficiencies, inability to fight infections or the person may neglect to take care of cuts and bruises when they become infected. If an excessive alcohol user has a spider angoras, can be seen specially in the upper chest area. Acne Roscoe, the red nose
Alcoholism is a chronic illness, psychic, somatic or psychosomatic, which manifests itself as a disorder of behaviour.

1. Alcohol and Cardiovascular Reactions:

Alcohol is a vaso-dilator which dilates the blood vessels. It increases the heart rate and output of blood in circulation. Excessive alcohol use weakens the heart muscle and leads to cardiomyopathy.

2. Alcohol and Gastro-Intestinal System:

In low concentrations, alcohol increases gastric secretion and hence acts as an appetizer. Heavy alcohol ingestion leads to erosive gastritis or inflammation of the mucosal lining of the stomach. Gastritis occurs due to the two fold action of alcohol, namely increasing gastric acid production and increasing the permeability of the mucosal cells to back-diffusion of gastric acid.

3. Alcohol and Respiratory Reaction:

Alcohol depresses the respiratory center in the brain. In cases of high doses of alcohol intake, death could result from respiratory failure.

4. Alcohol and Skin Reaction:

The skin disorders in alcoholics are a result of vitamin deficiencies, inability to fight infections or the person may neglect to take care of cuts and bruises when they become infected. If an excessive alcohol user has a spider angoras, can be seen specially in the upper chest area. Acne Roscoe, the red nose
of alcoholics may result from chronic dilation of blood vessels. Rhinophyma or 'Brandy nose' is a result of increase in nasal sweat glands which causes an increase in the size of the lower part of the nose.

5. Alcohol and Genitourinary Reactions:

There is a popular misconception that alcohol improves sexual functioning. There is a common misunderstanding that alcohol acts as an aphrodisiac, and apparently increases sexual functioning. This is totally wrong. Alcohol depresses that part of the brain that becomes less inhibited. The problem lies, however, with the fact that although the desire exists, sexual performance and capability are diminished (TTRCRF 1989).

1.4.3 Interpersonal Relationship and Alcoholism

Healthy interpersonal behaviour is spontaneous, expressive of the real self of the individual, versatile and flexible (Chunkapura, 1988). Excessive use of alcohol affects the individual interpersonal relationship. Quarrels between husband and wife, and other family members are common, alcoholism also leads to isolated behaviour. MacAndrews (1983) reported that the addicts tend to be aggressive and hedonistic. According to Cox (1986) addicts have poor impulse control, are bold, aggressive, pleasure seeking individuals non-conforming and have a strong need for immediate gratification. Alcoholics tend to score higher on the psychopathic deviance scale (Miller, 1976).
Alcoholism is widely labeled as a family illness because it sucks into vertex not only the alcoholic but those around him and its most damaging impact is felt in intimate relationships. Ruth (1956) who has worked with alcoholics for many years, has suggested that "probably no marriage with an alcoholic can be considered a happy one. There may be periods of relative harmony, but there is such a basic inadequacy in the one who drinks and lack of faith in human beings that the mutual trust and sharing necessary for a good relationship are absent". Armstrong (1958) in his studies says that Alcoholic is usually seen as a dependent, infantile person, dominated by his mother as a child, and very ready to be dominated by his wife.

1.4.4 Abnormal Symptoms and Alcoholism

Addiction to alcohol also develops abnormal symptoms. Not all symptoms are abnormal. These symptoms are more properly classified as personality disorders. When personality disturbances arises as a result of pathological state of the nervous system, the condition is called a brain syndrome. Excessive drinking results in temporary or permanent damage. Those states are classified as organic brain disorder. The five major types of brain disorders associated with alcoholism are; (1) pathological intoxication, (2) delirium tremens, (3) alcoholic hallucinosis, (4) alcoholic deterioration, and (5) Korsakoff's syndrome. (Kiskey, 1972). The first two types are acute conditions, the third type may be either acute or chronic, and the fourth and fifth types are chronic disturbances.

Depression is frequently associated with both alcohol and drug abuse. Depression is abnormal if it persists for a long time, is pervasive in nature, and
is inappropriate to stresses that occur in a person's life (Weissman and Paykel, 1974; Beck, 1967; and Becker, 1974).

1.5. PSYCHOLOGICAL TREATMENT FOR ALCOHOLISM

Treatment or therapy is directed toward the modification of maladaptive behaviour and the fostering of adaptive behaviour (Coleman et al., 1972). The psychological treatment aims toward personality growth in the direction of maturity, competence, and self-actualization. This involves the achievement of one or more of the following specific goals: (1) Increased insight into one's problems and behaviour, (2) A better delineation of one's self-identity, (3) Resolution of handicapping or disabling conflicts, (4) Changing of undesirable habits or reaction patterns, (5) Improved interpersonal or other competencies, (6) The modification of inaccurate assumptions about one's self and one's world, (7) The opening of a pathway to a more meaningful and fulfilling existence (Coleman 1972).

The effective treatment to addiction has been a challenge for all therapeutic approaches. Typically addicts seem at first to respond well to treatment but with in a few months or a year after therapy many have relapsed and resumed their old habits. This does not mean that addiction is incurable but it does point to the fact, that long term follow up therapeutic efforts are needed if an alcoholic dependent person is to be successfully made sober (Cautela, 1970). Some of the treatment methods have been described in the following paragraphs.
The psychological treatment is dominated by three major orientations i.e., the psychoanalytic, the behavioural, and the humanistic-existential.

1) The Psychoanalytic Therapy

Psychoanalysis deals with the unconscious mind in patients, and the deep rooted, hidden elements which make him turn to drugs. Mere physical treatment of an alcoholic addict is no absolute solution. His body might be weaned of the alcoholic, but mentally he remains unprepared to give up alcohol. Alcoholic addiction has to be uprooted from the minds of an addicts, which means that the root cause has to be eradicated.

Federn (1972) on the basis of chemical observation stated that all addicts suffer from a state of intolerable tension due to maternal neglect and lack of love. The psychoanalytic therapy emphasizes overcoming emotional repression and achieve true psychic health. This approach was derived from Freud (1912) original concept of catharsis and aberration in re-experiencing early trauma. Psychoanalysis takes as its aim the reconstruction of the personality and relief of symptoms by bringing to light and resolving central emotional problems of the patient’s childhood. It also accomplishes this task through the systematic use of free association, dream analysis, interpretation, and the transference neurosis, and extends over a long period of frequent sessions.
2) **The Behaviour Therapy**

Behaviour therapy is the use of experimentally established principles of learning for the purpose of changing unadaptive behaviour. Unadaptive habits are weakened and eliminated, adaptive habits are initiated and strengthened (Wolpe, 1969). Historically, behaviour therapy has its roots in the present century. When behavioural experiments conducted by Pavlov in classical conditioning and Thorndike in reward conditioning became popular. Until the 1950s, behavioural psychology remained essentially an academic laboratory discipline, with only rare application to the problems of human behaviour. Following the publication of B.F.Skinner’s Science and Human Behaviour and Wolpe’s Psychotherapy by Reciprocal Inhibition behavioural approaches began to assume an ever increasing importance to the mental health field. Behaviour therapy owes much of its growth to its continued interest in experimental investigations of the effectiveness of its various techniques. Behaviour techniques may include Relaxation Training, Systematic Desensitization, Assertive Training, Aversion Therapy, Covert Sensitization The Token Economy, Modeling.

3) **Humanistic-Existential Psychotherapy**

1) **Humanistic Psychology**

Maslow (1962) spoke of a "third force" in psychology, opposed to the dominant traditions of both psychoanalysis and behaviourism. In both, man’s behaviour is seen as determined and constrained, in one case by unconscious instincts and in the other by environmental conditioning. Both view man as less than fully human. Humanistic psychology, by contrast, sees man as having
purpose, values, options, and the right and capacity for self-determination, rather than being the hapless victim of his unconscious or of environmental reinforcement. Of his free will, he can maximize his potential for growth and happiness. The highest of human motives is the drive for self-actualization. The task of the therapist is to release this potential from limiting neurotic forces. The goal of therapy is to move one from being a deficiency-motivated person, dependent on the world about to provide him with gratification and to affirm his value as a person, to a growth motivated person, striving to enrich and enlarge his experience, knowing joy and true autonomy.

ii) Existentialism

The human experience should properly be center of concern for a philosophy of human life. Influenced by Husserl’s phenomenology and the spirit of the romantic movement, existential philosophy emerged in the writing of Kierkegaard and Jaspers and later contributions of Heidegger, Sartre, and others. There is no single existential philosophy, nor for that matter a unique psychotherapy related to it. Rather, existentialism is more an orientation toward understanding the nature and meaning of man’s existence. Some of the major themes in contemporary existentialism include: Man is free and has choice, Man is inextricably related to others and to his world, Existence implies nonexistence, Through encounter, man can grow and develop.

Apart from these three major approach of psychological treatments, we have number of other therapy too, such as Client-Centered Psychotherapy, Logotherapy, Gestalt Therapy, Rational-Emotive Therapy, Reality Therapy,
Technic of Biofeedback, Group Therapy, Family Therapy, Social Skill Training, Transactional Analysis, Positive self-concept Enhancement, Cognitive Modification, Thought Stopping, Meditation etc., Alexander and French (1946) describe the experience in this way: "In all forms of psychological treatment the basic therapeutic principle is the same, to re-expose the patient, under more favorable circumstances, to emotional situations which he could not handle in the past”.

An Alcoholic addict suffers from Emotional instability, Psychophysiological problems, Interpersonal conflicts and Abnormal symptoms as discussed earlier. Treatment from the Psychoanalytic, Behavioural, and Humanistic approaches would enable the addict to cope effectively and adequately to stress producing situations, channelise emotions effectively and improving the interpersonal skills. It also reduce the psychosomatic problems and abnormal symptoms.

1.6 PRESENT STUDY

In the year 1977 the World Health Organization Task force (Edward et. al.) proposed a two-axis model for diagnosing alcohol problems. The first axis, alcohol related disabilities, involves psychological, physical or social disorders that arise as a result of excessive drinking. The other axis the alcohol dependence syndrome, refers to a core syndrome characterized by impaired control over alcohol intake, tolerance and severe withdrawal symptoms (Edward and Gross, 1976). Both domains are viewed as existing in degrees rather than in an all-or-none condition, and there is empirical evidence to support this quantitative, multidimensional approach (Skinner 1982).
The efficacy of multifaceted behavioural approaches to alcoholism and its associated personal and interpersonal consequences. Miller et al. (1974a), describe such a program in force on a 15-bed alcoholism ward at the Veterans Administration Center, Jackson, Mississippi. Miller and his co-workers present a coherent behavioural rationale for their choice of the following three-fold behavioural approach to alcoholism treatment: (1) Techniques "to decrease the immediate reinforcing properties of alcohol", including electrical aversion, chemical aversion, and covert sensitization. (2) Development of "new ways of coping with life and incompatible with alcohol abuse", involving instruction in more appropriate ways to cope with stressful situations. (3) Alteration of his social and vocational environment so that the patient "receives increased satisfactions from life", these include family therapy and vocational counselling. Pomerleau and Brady (1975) also describe a similarly multifaceted treatment package.

The applications of a multifaceted behaviour modification program to alcoholism was given by Schaefer et al. (1971) at the Patton State Hospital in California. Sobell and Sobell (1973) were embedded within a 17-session treatment plan which dealt directly with the inappropriate behaviour of excessive drinking and emphasized a patient's learning alternative, more appropriate responses to stimulus conditions which previously functioned as setting events for his heavy drinking.

Keeping the above attempts in mind the present study was conducted to investigate the impact of psychological treatment on alcoholism. The effect of multifaceted psychological treatment to make an alcoholic sober, and to enhance
the interpersonal relationship, emotional stability, and also to reduce abnormal symptoms and psychophysiological symptoms was investigated. Assessment was carried out before and after the psychological intervention. A follow-up was conducted after a period of twelve months in order to measure the impact of the treatment. Some related review of literature, carried out for supporting the study is mentioned in the next chapter.
CHAPTER - II
REVIEW OF THE LITERATURE