CHAPTER - I

INTRODUCTION

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The "cup that cheers" has been eulogised for its many virtues by statesmen, philosophers, poets and writers but its detractors have been equally vehement in condemning it as the bane of mankind. While Winston Churchill claimed: "I have taken more out of alcohol than alcohol has taken out of me", the equally distinguished Bertrand Russell, a teetotaller denounced drunkenness as "temporary suicide" and the happiness it brings as "negative and momentary".

The widely acclaimed Tamil literary masterpiece of the Sangam era, the "Thirukural" highlights the evils of intoxication in several verses. It holds that "intoxication makes one mean enough even in the eyes of one's own mother" (verse 923) and that "it is crass foolishness that one should thus purchase unconsciousness" (verse 925).

Inspite of the bouquets and brickbats received by this "frothing brew" down the ages, which perhaps is indicative of society's long standing ambivalence towards it, there is no denying the fact that man has since time immemorial experimented with the use of several mood altering substances including fermented beverages.

Reference to the use of wine can be seen in Greek mythology and Hebe the adolescent daughter of the Greek god Olympus was the designated cup-bearer of the gods. The Bible (John 2:11) holds that of the seven miracles performed by Christ, the first was the conversion of water into wine. The ancient Syrian, Babylonian, Egyptian and Roman civilizations have also documented the widespread use of alcohol.

The use of fermented liquor and other intoxicating drugs in India dates back to ancient times (Indian Prohibition Enquiry Committee report 1954-1955). The point that intoxication and drug use have never been alien to Indian culture is highlighted by Simmonds in his book 'Alcohol, its production, properties and applications' where he mentions that distilled alcoholic beverages have been known in India since at least 800 BC.

In India during the vedic age, the use of liquor was widespread because it formed a part of the ceremonial and sacrificial rites. Two kinds of liquors - Soma and Sura have been mentioned in the Rigveda. "Sura" was an intoxicating drink distilled from grain used by the masses on ordinary occasions (Luniya, 1975). Its use was condemned in the later ages and the priestly class was not even allowed to touch it as it intoxicated the people and made them quarrel among
themselves (Tuteja and Varama, 1971). "Soma" was a terrestrial deity, the libation of which was regarded as specially sacred. The drink was extracted from the juice of plants that grows on the the "mujavat' peak of the Himalayas and its use was restricted to religious ceremonies. The importance of "Soma" can be realised from the fact that the entire chapter IX of the Rigveda has been dedicated to it (Majumdar et al. 1986).

Saha and Behaera (1988) note that Mauryan India imported large quantities of Roman wine. Bindusara (298-273 BC) wrote to Antiochus, the Greek Commander - "Send me sweet wine, dry figs and a sophist." The response from the other side was prompt. Except a sophist, the rest were sent! However common people drank distilled spirits often perfumed with mango blossoms. Liquor was taxed and its sale restricted.

Historians of later times have not failed to document the indulgence in wine of many of our rulers. Kai-qu-bad (1290), the son of Balban and the last of the slave dynasty before the Khiljis ascended the throne of Delhi, died a physical wreck owing to his passion for alcohol. Jahandar Shah (1712 -1713), the grandson of Aurangazeb spend his nights in drunken frolics and revelry. His brief reign of ten months was marked by chronic tippling and the resulting chaotic administration and pandemonium, eventually resulted in his death following a palace coup (Sharma, 1994).

Maharaja Ranjit Singh of Punjab died of a paralytic stroke due to excessive drinking in 1839, while entertaining Gov. Gen. Auckland at a party that went on for a month. It is reported that thirty tonnes of wine were consumed during this royal binge which ultimately became his feast of death (Cunningham, quoted from Grover and Grover, 1992).

Alcohol use was not introduced by the British in India, but its spread was facilitated by the personal example of an average Englishman (Mohan, 1987). The consumption was accelerated by the abolition of the pot-still distillation and starting of commercial production for revenue purpose.

It was under the influence of Mahatma Gandhi in 1937, that the Indian National Congress at its Madras session adopted prohibition as part of its programme. Later, prohibition became an integral part of the Bill of Rights at the Karachi session and after independence was incorporated into the Constitution as a Directive Principle of State Policy. Mahatma Gandhi’s birth centenary in
1965 was fixed as the deadline for imposing total prohibition throughout the country, but passed with precious little being done on the subject.

Politicians have for long continued to play ducks and drakes with our liquor policy and successive Government both at the centre and in states have never had a consistent approach. On the one hand is the enormous easy revenue generated by liquor sale for the exchequer and on the other, the urge to pander to the electorate particularly women by bartering prohibition for votes. In 1994 - 95 taxes on liquor contributed a revenue of Rs.18000 crore to state exchequers, around a third of the Rs.54,349 crore they earned through direct and indirect taxes (Pereira, 1996).

The Telugu Desam Government in neighbouring Andhra Pradesh came to power with total prohibition as one of its main election planks, introduced it in April 1995 and faced a grave financial crisis within a year owing to a revenue loss of Rs.1,300 crores. The Kerala Government closed down country liquor outlets from April 1996 and hiked up the excise on IMFL (Indian made foreign liquor) by 200 percent. The Harayana Government imposed prohibition from July 1996 and faces a revenue loss of 600 lakhs (Sunday, June 1996).

In Tamilnadu, the DMK Government revoked prohibition in 1971 after 34 years and besides IMFL, arrack and toddy (country liquors) filled the wine glasses of tipplers for nearly two decades. In 1991, the successor AIADMK Government, in all its wisdom decided to clamp down on country liquor but flooded the street with IMFL retail outlets and the status quo continues to this day.

The expensive prices of IMFL and the non-availability of cheap country liquor have pushed the thirsty lower classes into the clutches of easily available illicit liquor. This has often resulted in hooch tragedies as happened recently (September, 1996) in neighbouring Pudukottai when thirty people lost their lives. Prohibition then whether total or partial may not be the right approach in dealing with alcoholism. Kushwant Singh (1975) ends an article on prohibition in the Illustrated Weekly of India with the observation that our aim should be "temperance not total abstinence; persuasion not prohibition".

PREVALENCE OF ALCOHOL USE

An idea of the extent of alcohol consumption in India can be had from the fact that the national average per capita consumption of alcohol in 1994 was
5.7 litres (The Week, April 1996). Kerala with a per capita consumption which is higher than the national average (8.3 litres in 1994) is perhaps second only to Punjab in the country (Kumar, 1992). Liquor consumption in India is estimated to be growing at 15 percent per annum (Chakravarthi, 1995).

Given the nature of the phenomenon, it is perhaps not realistic to expect an accurate estimate of the prevalence of alcohol use and dependence at the national level. In a review of epidemiological studies of alcohol abuse in India, Singh (1989) observes that despite several studies conducted in different parts of the country, it is difficult to generalize at the national level owing to various methodological limitations such as non-representative population groups, difference in sampling, definition of terms, assessment measures and different criteria used to ascertain what constitutes alcohol abuse.

A few general psychiatric morbidity surveys have enabled the determination of alcoholism rates. Surya et al (1964) reports an alcoholism rate of 3.6 per thousand in Pondicherry following a survey of 2731 people belonging to 510 households. Thackore (1972) found alcohol dependence rate to be 18.6 per thousand in Lucknow. Elnager et al (1971) surveyed 1383 people from 184 families in a rural community in West Bengal and reported a prevalence rate of 13 per thousand while Nandi et al (1970) in a similar community arrived at an estimate of 19 per thousand. Verghese et al (1973) surveyed 2904 persons of 539 families using a stratified random sample in Vellore town (Tamilnadu) and reported a prevalence rate of 4.8 per thousand, according to ICD-8 diagnostic criteria.

A study by Mathrubootham (1989) in a rural Tamilnadu sample found that 33 percent of men were current alcohol users and most of them belonged to the lower socio-economic status. Similarly, Chakravarthy (1990) in a survey of rural areas of Tamilnadu arrived at an estimate of 26 to 50 percent of men as being alcohol users. A survey of alcohol use in Madras city by Ponnudurai et al (1991) estimated prevalence to be 16.67 percent of the male population.

Several studies have been done to determine alcohol use rates among special population groups. Among doctors and paramedical staff such as pharmacists, Singh and Jindal (1981) found usage rates ranging from 44 to 66 percent. Among University students of Chandigarh, Varma and Dang (1980) report an alcohol use rate of 21.6 percent while a figure of 32.6 percent has been
reported by Dube (1978) from Agra. A multicentered collaborative study by Mohan et al (1981) in nine different Universities of India obtained a fairly consistent figure of 10 to 15 percent. That alcohol use has also permeated to teenagers is indicated by the study from Delhi where Mohan et al (1975) found 12.7 percent of current alcohol users among high school students.

High usage rates have been reported among industrial workers. In a study of the workers of the Madras Port Trust, Chengappa (1986) found that almost 50 percent of them were regular alcohol users. Higher prevalence rates have been reported for industrial workers in Punjab where Gargi and Goyal (1992) reported that while about 60 percent of them were alcohol users, many of them were only recreational users.

Hospital admission rates are fair indicators of alcohol abuse prevalence rates in a community. From 120 outpatient consultations for alcohol-related problems at the Pondicherry General Hospital in 1990, the number of patients rose to 254 in 1993 (Murthy, 1994). At the National Institute of Mental Health and Neuro Sciences, Bangalore about 20 percent of all patients in 1990 reported with alcohol use-related disorders, the corresponding figures being less than 2 percent a decade earlier in 1980 (Isaac, 1990). In 1994 out of a total of 9465 patients 998 were admitted for alcohol dependence and in 1995 the figures were 646 out of 7063 admissions, which is approximately 10 percent.

At the Institute of Mental Health Madras, Somasundaram (1985) reports that during 1966 to 1981, the percentage of admission for alcohol problems ranged from 0.1 to 3 percent of the total admission. In 1994, Palaniappan and Soundarajan note that more than 25 percent of the admissions related to alcohol problems.

Thus the review of epidemiological studies in India shows that alcohol use is more among men with higher rates for industrial workers. Singh (1989) estimates that the national prevalence rate would range between 20 to 30 percent with a per capita consumption of 10 litres per annum.

**ALCOHOLISM : THE DISEASE CONCEPT**

The term "alcoholism " has endured usage for a long time since it was coined in 1847 by the Swedish doctor Magnum Huss (Madden, 1980).

The World Health Organisation's (1952) official definition reads in part, "Alcoholics are those excessive drinkers whose dependance on alcohol has attained such a degree that it shows a noticeable mental disturbance or an
interference with their bodily and mental health".

The American Medical Association in 1956 officially recognised alcoholism as a disease to be treated by physicians.

The American Medical Society of Alcoholism Committee on definition (1979) also held alcoholism to be a "chronic, progressive and potentially fatal disease or pathological organ changes or both"

The rationale behind the disease concept is that like any other clinical illness, alcoholism has an aetiological agent (alcohol), pathogenesis (ill effects on body systems), and a syndrome (collection of symptoms).

Vaillant (1983), observes that the term "disease" has been used to underscore the point that once an individual has lost the capacity consistently to control how much and how often he drinks, then continued use of alcohol can be both necessary and a sufficient cause of the syndrome labelled alcoholism.

The disease concept has also helped to lessen the stigma of moral turpitude associated with alcoholism and made it possible to provide medical and psychological treatment to the alcoholic instead of dealing with him through punitive measures.

Rather than being a biological disorder, alcoholism has been considered by many to be a disorder of behavior. To quote Thomas Szasz (1972), "Excessive drinking is a habit. If we choose to call bad habits "diseases" their is no limit to what we may define as a disease".

Other criticisms against the "disease" conceptualisation hold that the medical model of alcoholism places its causation "within-the-individual" and underplays the role of socio-cultural factors. Further, the disease label can provide alcohol abusers with a means of avoiding responsibility and places the onus of treatment on the physician.

The T.T.Ranganathan Clinic research foundation's master guide (1989) characterises alcoholism as a primary, progressive, terminal but treatable disease. In line with this concept is the notion that alcoholism can be successfully arrested but not cured and treatment is directed towards the goal of total abstinence. All de-addication centers in our country direct their intervention programme towards the goal of total abstinence unlike some centres abroad which strive towards the achievement of "controlled drinking" behaviour.
The WHO recommended that the term "alcoholism" be discarded and substituted by "ALCOHOL DEPENDENCE SYNDROME" (ADS) and subsequently this term has been used in the ninth revision of the International Classification of Diseases (ICD-9) published by it in 1978.

**TYPES OF DRINKERS** (Catanzaro, 1977)

1. Total abstainers
2. Moderate or Social drinkers.
3. Sporadic excessive drinkers.
4. Heavy social drinkers.
5. Alcoholic drinkers.

Not all alcohol users are alcoholics and it is only the last category of people who have developed the disease of alcoholism.

**CLASSIFICATION OF ALCOHOLISM**

Jelinek (1960) has classified alcoholics into four major types.

ALPHA ALCOHOLISM: purely psychological dependence to relieve bodily or emotional pain.

BETA ALCOHOLISM: medical complications owing to heavy drinking in the absence of physical or psychological dependence.

GAMMA ALCOHOLISM: progression from psychological to physical dependence and a marked deterioration of behaviour. Loss of control over alcohol use.

DELTA ALCOHOLISM: inability to abstain from drinking and experience of withdrawal symptoms.

**STAGES OF ALCOHOLISM**

Jelinek (1960) delineated four distinct phases through which the disease of alcoholism progresses if untreated.

**PHASE - I: THE PRE - ALCOHOLIC PHASE**

This phase lasts from six months to ten or more years and has two main features: 1. The future alcoholic attempts to alleviate everyday tensions by drinking and is not yet considered to be a problem drinker.

2. Drinking frequency increases, progressively large amounts are consumed to gain the same effect.

**PHASE - II: THE EARLY ALCOHOLIC PHASE** (Non-addictive alcoholism)

This phase may last from six months to ten years and the drinker slips
imperceptibly from phase - I to this phase. The addiction in this stage is psychological and the drinker may show characteristics such as black outs, pre-occupation with alcohol, sneaking drinks, gulping, experiencing guilt feelings about his drinking behaviour and avoiding reference to alcohol in conversations when sober. He starts being considered to be a "heavy drinker" by others and may use defenses such as denial, projection and rationalization to relieve his anxiety and to continue his drinking behaviour.

PHASE - III : THE CRUCIAL PHASE (Addictive alcoholism)

Loss of control over alcohol is the prominent characteristic of this phase and the alcoholic may consume alcohol to the point of drunkeness. Addiction progresses to physiological dependence and he may show grandiose behaviour, aggressiveness and develop withdrawal symptoms on cessation of drinking. He may get into problems with the family, workspot, friends and may develop health problems. He may attempt periods of abstinence or changing his drinking pattern in this stage.

PHASE - IV : THE CHRONIC PHASE

He may develop a loss of tolerance to alcohol and small amounts get him severely intoxicated. He may go on prolonged, unplanned drinking sprees lasting for several days and show ethical deterioration and intellectual impairment. Medical complications such as liver cirrhosis, brain damage and gastric complications may manifest in this stage.

Catanzaro (1977) observes that the predictable down hill progression of alcoholism can in a large number of cases be arrested at any stage with therapeutic intervention.

ETIOLOGY OF ALCOHOLISM

As with its definition, theories of the etiology of alcoholism are numerous and diverse. However, inspite of several empirical researches pertaining to etiology of alcoholism, no single theory has proven adequate to explain this complex syndrome and consequently it may not be realistic to attribute one single cause to be responsible for its manifestation. The following section provides a brief overview of various theories and models pertaining to the etiology of alcoholism.

PHYSIOLOGICAL AND BIOLOGICAL MODELS

These theories hold in essence that certain individuals are by virtue of some
organismic defect, constitutionally predisposed to develop alcoholism. Alcoholic behaviour is viewed as resulting from a medical condition (i.e., alcoholism) which in turn, arises from an underlying biological malfunction (Armor et al., 1978).

**GENETIC THEORY**

Alcoholism has been for long attributed to be a familial disorder since its prevalence rates are far higher among relatives of alcoholics than among the general population (Goodwin and Guze, 1974). Adoption studies by Goodwin et al (1973) and Schuckit et al (1972) showed that the presence of alcoholism in biological parents is of far greater predictive significance than the presence of alcoholism in adoptive parents, in the development of alcoholism in children who have been separated shortly after birth.

**ENDOCRINE THEORIES**

Hypoglycemia caused by pituitary - adrenocortical deficiency (Gross, 1945) and hyperthyroidism (Richter, 1956) have been implicated as causal factors in alcoholism. However, controversy exists whether endocrinal dysfunction is more the effect rather than the cause of alcoholism.

**GENOTROPHIC THEORY**

According to this theory postulated by Williams (1947), alcoholism results from an inherited metabolic defect that causes the need for increased intake of certain dietary substances in order to compensate for their deficiency. However, adequate empirical support for this proposition has not been forthcoming.

**PSYCHOANALYTIC THEORY**

The Freudian view holds alcoholism to be a result of traumatic childhood experience, faulty parent child relationship, oral fixation, self-destructive impulses and latent homosexuality. Perls et al (1951) in their book on Gestalt therapy describe an alcoholic as an "adult suckling" suffering from oral underdevelopment.

Barry (1974), holds that the functional significance of alcohol lies in its ability to maintain and enhance regression and denial in individuals whose personalities function at an immature level of development.

The Adlerian perspective believes that alcoholism represents a striving for power, to compensate for a pervasive feeling of inferiority and powerlessness coupled with strong inhibitions against the expression of hostile or aggressive impulses.
Intra-psychic conflict between intense dependency needs and a striving for autonomy and independence has been held to be characteristic of the alcoholic's personality.

PERSONALITY TRAIT THEORIES

Trait theorists have highlighted the existence of specific personality traits which differentiate alcoholics from non-alcoholics. Low self tolerance (Lisansky 1960), high anxiety levels (Barry 1974, Vogel-Sprott, 1972), dependancy (Blane, 1968), negative self-image, feelings of isolation, insecurity and depression (Irwin, 1968, Weingold et al., 1968, Wood and Duffy, 1966) have been identified as some personality traits commonly seen in alcoholics. However, the existence of a typical pre-morbid personality has been refuted by several authors (Armstrong, 1958 : Rosen, 1960).

The most serious limitation of the trait theories has been their inability to establish whether these personality traits predisposed the individual to alcoholism or were its consequence.

LEARNING AND REINFORCEMENT THEORY

The Pavlovian classical conditioning model views alcoholic behaviour being maintained as a result of the association formed between alcohol ingestion and the positive rewarding experiences in terms of its tension reducing and relaxation providing properties.

Bandura (1968), explains the development of alcoholism using a two-stage operant conditioning model. In the first stage, alcohol use is reinforced by its pleasant anesthetic properties. Prolonged alcohol use results in alterations in the metabolic system consisting physiological addiction. In the next stage, the distressing withdrawal symptoms experienced owing to non-consumption of alcohol, by themselves become the stimulus condition for renewing alcohol consumption and thus the addiction cycle is perpetuated.

SOCIOCULTURAL THEORIES

The use of alcohol, attitudes towards its use, mores regulating drinking patterns and environmental support for drinking are largely determined by cultural factors. Children are socialized into culturally prescribed beliefs, attitudes and practices regarding the use and consumption of alcohol.

Familial patterns of alcohol consumption may provide faulty role models for children to imitate. Situational crises such as loss of job, death of spouse, and
marital instability may precipitate heavy drinking when an individual's normal coping mechanisms fail to deal with the accompanying stress. Heavy alcohol consumption may occur in response to changes in one's social environment that create aversive stress; this excessive drinking in turn results in further deterioration of social adjustment, creating even greater stress and perpetuating the alcoholism process.

THE MULTIVARIATE APPROACH

None of the theories mentioned earlier have been adequate by themself to account for the multiple causes and complex developmental course of alcoholism. Hence there is a need for a multifaceted approach, integrating significant elements of various theories in order to provide a more adequate perspective.

Plaut (1967) using such and integrated model propounds that; An individual who (i) responds to alcohol in a certain way, perhaps physiologically determined by experiencing intense relief and relaxation, and who (2) has certain personality characteristics, such as difficulty in dealing with and overcoming depression, frustration and anxiety, and who (3) is a member of a culture in which there is both pressure to drink and culturally induced guilt and confusion regarding what kinds of drinking behaviour are appropriate, is more likely to develop a problem with drinking.

CO-DEPENDENCY

Alcoholism has for long been recognised as a family disease. This implies that as the alcoholism advances, the family also gets progressively enmeshed with the disease and develops pathological features. The term "co-dependency" means being a partner in dependency. It is used to describe a person whose life has become unmanageable as a result of living in a committed relationship with an alcoholic, owing primarily to the intense trauma and stress experienced in such relationships (Gorski and Miller, 1984).

Co-dependency is a primary disease in members of an alcoholic's family who try to adapt with a sick family system that seeks to protect and enable the alcoholic (Sharon Wegscheider - Cruse, 1979). It is a dysfunctional pattern of living and problem solving which is nurtured by a set of rules within the family system (Subby and Friel, 1984).

The co-dependent who assists in maintaining the social and ecological
equilibrium of the alcoholic. The co-dependent is primarily the alcoholic's wife (Kaminer, 1990) who may learn controlling behaviour such as protecting the alcoholic from employers, law, friends and extracting penance from him in the form of emotional subservience. This stimulates the alcoholic's low self worth which in turn tightens the control of the co-dependent. As the control progresses, the co-dependent becomes preoccupied with the alcoholic upon whom she depends in order to feel needed.

Co-dependents may develop traits such as difficulty in identifying and expressing feelings, forming and maintaining close relationships, perfectionism, rigidity, difficulty in adjusting to change, low self-esteem, sense of shame, feelings of powerlessness, deficiency in decision making and constant need for others approval (Subby and Friel, 1984).

Spann and Fischer (1990), observe that co-dependents manifest a dysfunctional pattern of relating to others characterised by: extreme focus outside of self, lack of open expression of feelings and attempts to derive a sense of purpose through relationships.

While traits of co-dependency have been attributed as emerging consequent to a prolonged close relationship with an alcoholic, co-dependent behaviour patterns have also been considered to be important factors in perpetuating and maintaining the spouse's alcoholism.

This study does not focus on the alcoholic per se but investigates the most important co-dependent in an alcoholic marriage namely the alcoholic's spouse.