CHAPTER 1
INTRODUCTION

1.1 Alcoholism
1.2 Alcohol Problem
1.3 History of Alcoholism
1.4 Alcohol Abuse in India
1.5 Gandhian Approach to Alcoholism
1.6 Family as a Social System
1.7 Alcoholism: The Quest for Transcendence and Meaning
1.8 Medical Aspects of Alcoholism
1.9 Psycho Social Aspects of Alcoholism
1.10 Evaluation and Management
INTRODUCTION

1.1 Alcoholism

The word ‘alcoholism’ was first used by Magnus Huss. The word ‘alcohol’ has been derived from the Arabic word ‘Al-kuhul’ meaning “essence”.

Alcoholism as a disease was accepted in the 19th century by a large proportion of the medical community. Many alcoholics demonstrate an excellent ego strength as evidenced when their addiction is corrected. Alcoholism progresses through several stages of varying length, depending on the individual. During the onset of alcoholism it may be difficult to distinguish the alcoholic from the heavy drinker. One sign of alcoholism may be that alcohol has become a requirement for pleasure of enjoyment rather than an accompaniment to it. As the illness progresses blackouts become common. Subsequently the alcoholic experiences loss of control over drinking. Finally the alcoholic ‘reaches rock bottom’ at which point he may either seek help or drop out of normal life entirely.

Alcoholism cannot be cured, but sufficiently arrested if early intervention takes place and the individual is properly motivated. An alcoholic can never become a social drinker, since just one drink may trigger the craving for alcohol and he may end up again in alcoholism. An alcoholic can be sober for many
years, but there is always the danger of an impending relapse. Accordingly, it is a permanent disease. Death can result if the progress of the disease is not arrested.

Alcohol use is mainly a male prerogative, which was the consistent finding in all the studies. While the male alcohol users fell in between 50%-75%, the female users were very low and invariably less than 5%. The early initiation to alcohol around the age of 15-25 was reported by most of the studies (Kumar 1991¹, Selvaraj et al., 1997²).

Edwards and Gross (1976)³, introduced the concept of alcohol dependence syndrome "as a cluster of core psycho physiological symptoms principally centred around a drive to consume alcohol". The concept had a tremendous influence in the field of alcohol studies. It was included by the World Health Organisation (WHO) as one of the components of alcohol related disabilities. The dependence syndrome is considered as a process, distinct from other alcohol related problems such as social, legal, work or health problems, and this was accepted by all international classificatory systems (WHO, 1992)⁴.

The alcoholic and the non-alcoholic start drinking alcohol in the same way and for the same reason but as his drinking progresses, he consumes alcohol to gain effects of alcohol, to feel euphoric, stimulated, relaxed or intoxicated. Many a time he drinks to get rid of his frustrations, at other times he drinks to keep up his cheerfulness. If he is tensed, he drinks more than ever in an efforts to unwind, to get his mind off his problems; if depressed or introverted he may
drink to gain confidence and courage, if extroverted, he may drink to enjoy the company of others who drink.

Undoubtedly over the last ten years the habitual excessive use of alcohol and different levels of alcohol dependence with the physical and psychiatric consequences have substantially increased. Alcohol which was an elite delicacy in the dining hall of the high social strata, or an evening relaxation ritual for the working class men, have permeated into all social classes, and age groups. Persons with alcohol related disorders occupy not less than one third of the hospital beds.

To call a behaviour as an addictive behaviour two things are necessary, i.e. 'urge' and 'craving'. Urge means an irresistible impulse to do a particular thing whatever be the act or the consequences; they are not able to resist the urge. Craving is an urge to experience the consequences or effect produced by a particular act. Addictive behaviour, whether involving the abuse of substances such as alcohol or cannabis or the excessive injection of high calorie food resulting in extreme obesity is one of the most pervasive mental health problem in the society today. The most commonly encountered problems are the psychoactive drugs and alcohol. The most important predisposing factors are a tendency to be emotionally immature, to expect a great deal from the world in terms of praise and appreciation, to react to failure with marked feelings of hurt
and inferiority, to have low frustration tolerance and to feel inadequate and unsure of the ability to fulfil expected gender and social roles.

Substance abusers also have low stress tolerance, negative self-image, feelings of inadequacy, isolation and depression. By the time the individual seeks treatment, there is deterioration in the personality indicating a lack of responsibility, impaired impulse control and at times, a tendency to deceitfulness. Alcoholism is viewed here, as a solution to the problems of social adjustments for individuals whose differing personality traits render them vulnerable to finding them a suitable place in society.

1.2 Alcohol Problem

The World Health Organisation is actively engaged in a major campaign, “Health for all by the year 2000”, but the greatest threat to the achievement of this goal is the menace of alcoholism. Considerable efforts have been directed toward determining factors associated with alcohol related problems and alcoholism in contemporary society. Patridge (1972) stated that “our problem is the origin, nature, course of development, and the meaning of these traits of human nature, and the social life which have led men to use, to enjoy, to become habituated to, and sometimes to be destroyed by intoxicating drinks”.

It is possible that different regions in India are very diverse and there is a real variation in the magnitude of the problem. Chick (1994) reported that “the
detection and study of alcohol misuse in general hospital environment is a neglected area⁶. The excessive drinkers are at high risk health problems and many of them are hospitalised for these problems either as a primary diagnosis or as a complicating factor. This may account for “about 10% to 50% of the inpatient population in the general hospitals” (Moore et al., 1989)⁷.

It is known that man has been using alcohol and other substances for varied reasons. The most common reasons for their use have been either to seek relief from pains or to derive pleasure and/or for achieving new experiences. Today the age-old cherished values of abstinence or their limited and restricted use in certain social situations is gradually but surely fading away. Today their use is not only restricted to one culture but is crossing all the cultural barriers. The problem has become more ubiquitous in recent times and has ballooned to a degree which requires urgent interventions at different levels.

The problem of alcohol abuse as such is not unique to India alone but India has become a major transit country. Due to this, there is an alarming increase in drug related problems. With rapid industrialisation and migration of the population, with economy of abundance associated with multitude of frustration and tension ridden families, the problem is not likely to be controlled unless early remedial actions are taken by the various Government Departments and other voluntary organisations in the matter.
We have to confront a large array of problems like rapid urbanisation and industrialisation leading to fast migration from rural to urban setting, resulting in disorganisation of traditional family structure and other related social changes with consequent disruption of the traditional value systems, life style and support.

1.3 History of Alcoholism

Alcoholism is one of man’s oldest universal problems. The use and abuse of alcohol is well documented in the ancient writings of Babylon, Mesopotamia and Egypt. Alcohol use and abuse is in our myths, lore’s, culture and religion. In Biblical legends, the discovery of wine is also related to stories of creation. Getting drunk with wine was always condemned in Bible. Early civilizations present numerous records of the production and consumption of alcoholic beverages. All societies, whether civilized or savage, have made use of intoxicating drinks of some kind from time immemorial. Modern research has established the fact that alcoholic beverages were prepared from cereals by the Mesopotamians dating from 400 BC, although actual production may have begun 200 years earlier.

In the early contemporary Egyptian societies, however, the predominant alcoholic beverage was Beer, fermented from barley called ‘hek’, and its use was intimately connected with sacrificial rites performed in those days. The Egyptians
taught the art of brewing to the Jews and Greeks, and the latter transmitting their knowledge to the Romans.

India has always been described as an abstinent culture. There is sufficient evidence indicating that consumption of alcoholic beverages was looked upon with disapproval by Hindu Scriptures and society. However, the use of alcohol has been described all through Indian history. The intoxicating properties of alcohol, referred as som-ras in earlier Indian text (Vedas) dates back to 1300-1000 BC. There were no definite cultural traditions in India, which could be described, as being clearly and unequivocally against the use of alcohol in any form and under all circumstances. Although, alcohol was often referred to as an evil, it was at the same time socially accepted and glamorized by its use among the ruling classes.

1.4 Alcohol Abuse in India

The history of alcohol abuse in India is not very different from the rest of the world, except that the distinctive features of its use in India have been the association with social and religious activities. Mahatma Gandhi, father of the nation, clearly indicated the significance and magnitude of the problem. Mahatma Gandhi had said, “If I were appointed dictator for one hour for India, the first thing I would do would be to close down without compensation all liquor shops and toddy palms”.

Alcohol dependence is a major public health problem in many developing countries. Epidemiological studies conducted in India show high prevalence of alcohol dependence. The follow up studies in India suggest that significant proportion of these patients do respond to intervention. Nationwide information on the incidence and magnitude of the problem of alcoholism is not readily available. A review of the epidemiological studies in India showed that alcohol use was limited to a minority population of 20%-35%. The rates are high among the student population in general (6%-15%) and the medical students in particular (40%-50%) and other professional groups. In 1964, the study team of prohibition estimated that consumption of alcohol was common among 10.24 per cent of the working class families in the country (Sethi et al., 1979\(^9\), Mohan et al., 1983\(^{10}\), Premarajan et al., 1993\(^{11}\), Sateesh Babu et al., 1997\(^{12}\)).

In India poverty and alcoholism creates a vicious cyclical relationship, which seemingly damages the families of alcoholics. The steady increase in the number of teenage drinking, road accidents, crime, the women alcoholic and many other social problems are attributed to alcoholism. Therefore a thorough understanding of this problem is necessary to check this social malady effectively. It is unfortunate that there is a dearth of scientific works on this topic in our country.
1.5 Gandhian Approach to Alcoholism

Mahatma Gandhi, father of the nation, contributed various tailored-approaches in order to tackle the problem of alcoholism. In fact, he observed that many young men especially the youth were consuming alcohol and their families were seriously affected due to such alcohol abuse. In short, Gandhi viewed life as a whole, an integrated and indivisible whole and every aspect and part of it was looked upon as vitally significant in the constitution of the whole. His deep concern over the physical and mental torture faced by women and children due to drink evil gives considerable importance. The main contribution of Gandhi to the cause of women lay in his absolute and unequivocal insistence on their personal dignity and autonomy in the family and in society. But if women were to assert themselves in family life, wives should not be dolls and objects of indulgence, but should be treated as honoured comrades in common service.

Gandhiji’s experiences in London and South Africa facilitate a major landmark in dealing with the problem of alcoholism in India. Synoptic view of life in South Africa, he found that too many Indians among whom hundreds of indentured men and women were given to alcohol. So it was in South Africa where he initiated his anti-liquor campaign. Keeping in view of the non cross-cultural variations and similarities in the patterns of drinking and the alcohol
dependence, Gandhiji admitted that alcoholism is a social evil because of its harmful effects on family, work, society and health of the alcoholic himself.\textsuperscript{13}

He could observe that alcohol which produces so much domestic violence including murder, poverty, sexual abuse, family disorganisation, ruined health and physique.\textsuperscript{14} He narrated the condition of the drunken person and his behaviour towards his family members. According to him, “those who are given drink often cannot distinguish between wife, mother and daughter. Man degenerates into brute. Who ever gets entrapped in this vice becomes an animal.” \textsuperscript{15}

In shaping his attitude to the drink evil he pointed out that in a country like India family plays a vital role in the daily life of people.\textsuperscript{16} Moreover, his primacy to the moral and spiritual growth of the individual and family is inevitable. It is documented that drink and drug destroy the moral and spiritual growth of a person and his family. Hence the moral and spiritual development of family and society were given importance by the implementation of prohibition. In his action programme to tackle the problem of alcoholism and its associated evils, prohibition was given a place of prime importance. Gandhiji believed that Indian villages will have new life and prosperity only when the drink evil is abolished.\textsuperscript{17}

As pointed out earlier, the social environments of the alcoholics and his family were given prime importance. At work, Gandhiji observed that majority
of the factory labourers were under the influence of drink because after the long hours of work they have no other alternatives for recreation. Therefore, he pointed out that the task is not merely asking the people to change their habit, but providing better facilities for them to attract their mind to sober things.18

Gandhiji, from his experiences in India and abroad, eventually, was convinced that true swaraj (freedom from all bondages) cannot be achieved without weaning away the poorest sections of our population from this monstrous social evil. In his action programmes, importance was given to establish treatment centres. He stressed the role of voluntary organisations, youth and students in educating the public, role of liquor contractors and liquor dealers. He also pointed out that no permission should be given for the opening of new shops. The impact of satyagraha (holding fast to truth or adherence to truth) was given prominence.

Keeping this social evil in a Gandhian framework, the approach to this social problem is a holistic one in which every family and society have significant role to play.

1.6 Family as a Social System

Development of treatment approaches that recognize the family as a system is important. When alcoholism is inserted into the family system, a shift in equilibrium is created. The entire family tends to respond by creating strategies to
deal with the painful stress. These strategies are designed to maintain the previous level of family equilibrium. Family roles become blurred or distorted, and rigid rules dictating the interaction between family members are developed.

The family functioning is guided by the belief that the individual’s use of alcohol is the most important aspect of family life. However, alcohol is not considered the cause of the family’s problems. Some one or something else is believed to perpetuate the alcoholism. The person suffering from alcoholism is therefore not held responsible. The status quo must be maintained, thus family members diligently cover up for the individual’s alcohol related indiscretions. No one may discuss what is really happening nor share true feelings.

Wegscheider (1981) stated that “each family role hides feelings and contributes a valuable function to the family”. For example, the chief enabler, often the spouse, is super responsible and increasingly assumes the duties vacated by the alcoholic. The family hero, through efforts of achievement, brings a sense of pride to the family while simultaneously covering up the family’s fear of failure. The scapegoat’s angry defiant behavior removes the family’s focus from alcoholism so that denial of parental alcoholism may continue. The scapegoat expresses for the entire family the anger and rage engendered by the alcoholic. If the alcoholic attempts abstinence, there may be strong pressure from the rest of the family system for the individual to resume drinking. To maintain the system’s balance or previous level of homeostasis, the family as a whole may
actually sabotage individual attempts to discard dysfunctional roles. Upon completion of treatment level, the family relinquishes maladaptive role behaviors. The family develops improved coping mechanisms, thereby weakening the family’s reliance on maladaptive roles. Emotional development or growth occurs as the family obtains insight that confronts any remaining use of maladaptive role behaviors.19

1.7 Alcoholism: The Quest for Transcendence and Meaning

Alcoholics struggle with the existential dilemmas of freedom and responsibility and are often unsuccessful because they develop insight and understanding, yet fail to change their behavior. This is the downfall of insight-oriented psychodynamic therapies. Alcoholics Anonymous (AA) has overcome this problem through the use of twelve steps, which emphasize engaging in new behavior and progressive activity rather than just awareness of the problem. Alcoholics Anonymous members learn early slogans like “Faith without works is dead” and “Fake it until you make it”, which communicate the importance of taking action and doing new behavior. This is an important principle of successful work with alcoholism. Behavior change must accompany if not precede new insight for permanent change to occur (Johnson et al., 1987).20

In the rush to attain scientific dominance and capture the rewards of market share, mainstream knowledge of alcoholism has been overly narrowed.
The experience of being alcoholic, and the meaning of the relationship with alcohol, is lost in a scientific shuffle. None of the modern experts’ approaches to alcoholism are very effective in helping people modify their destructive drinking. The present study has suggested an explanation of alcoholism and recovery broader than that offered by the dominant paradigm. More than just learning a new way to drink, or not to drink, recovery is a holistic and transpersonal experience. The alcoholic’s relationship with alcohol lies at the core of his or her being. Although largely ignored by western science, the importance of the spirit in recovery from alcoholism has long been acknowledged. Mary Richmond (1920) instructed social workers that “conversion experiences as might be found in religion were the most effective form of treatment for the alcoholic.” Recovery from alcoholism required an experience beyond mere rationalism”. If we are to improve our ability to help persons with alcohol problems we must look beyond the current scientific paradigm. Greater understanding of alcoholism recovery will be revealed by expanding sources of knowledge rather than through further reductionism. We must pay more than lip service to the principles and approaches described here. Until we do, clients with alcohol problems will not experience the struggle and triumph of making meaning for their lives.
1.8 Medical Aspects of Alcoholism

Alcohol is a chemical substance called ethyl alcohol which is present in various alcoholic beverages. Alcohol is a colourless liquid prepared mainly by termination of various food substances. Alcoholic beverages are of different types. These include brandy, whisky, rum, gin, arrack, wine and beer etc. In each of these beverages the content of alcohol varies. Drinks such as whisky, brandy, arrack, gin and rum contain 40-55% of alcohol. Wine contains 10-20% of alcohol and beer contains 6-8% of alcohol.

When consumed, alcohol passes in the stomach. It does not require any digestion like other food substances; it passes directly through the walls of the stomach and intestines into the blood. About 20% of alcohol consumed is absorbed from the stomach wall and about 75% from the intestines. When alcohol enters into the blood, it gets circulated throughout the body. Since it does not require any digestion, and is circulated throughout the body in the blood, the alcohol effects will be experienced by the drinkers within a very short time after its consumption.

The effects of alcohol in the drinker depends on various factors. These include:

i. Concentration of alcohol in the beverage;

ii. Amount of alcohol consumed;
iii. Speed with which alcohol is consumed: and

iv. The drinker’s body weight

When taken in small quantities, alcohol reduces the feelings of anxiety, worry and tension. Hence individuals use it in order to get relief from these problems. People who are inhibited, drink as they feel comfortable and less inhibited in interacting with others. However, alcohol consumption can also lead to poor co-ordination of limbs and slurring of speech.

People start consuming alcohol for various reasons. When a person starts drinking regularly, he would develop ‘tolerance’. This means, though the individual initially takes alcohol in less quantity, he has to gradually increase the quantity over time, in order to get the same effect which he was getting with smaller quantities of alcohol previously. Due to this tolerance, the individual would tend to increase alcohol consumption gradually over a period of time. After some time, the pattern of occasional drinking, would become more frequent and he would start drinking everyday, in large quantities. If he discontinues drinking temporarily, he would develop problems such as shaking in hands and legs, sweating, headache and not being able to perform his activities. This is called dependence. When he becomes dependent, he would start drinking in larger quantities and more frequently in order to reduce the problems related to withdrawal.
As the individual becomes a chronic drinker, though he would attempt to drink less, due to the loss of control he cannot control his drinking and drinks to the extent of becoming totally intoxicated. Due to the severe and serious negative consequences and due to the individual’s loss of control over drinking, it is always essential to give up drinking completely. When a person drinks alcohol, most of it is directly absorbed into the blood from stomach. Because of its direct action on the stomach it causes various problems such as ulcers, bleeding from stomach, cancer of stomach etc. The remaining alcohol passes through liver, causing damage to it. Increasing liver damage can lead to death. When a person takes alcohol in excessive quantities, his food consumption is reduced, leading to malnutrition.

When larger quantities of alcohol is consumed, it can harm the heart and hence leading to death. Continuous alcohol intake can also affect muscles, blood, individual’s sexual life, brain and this lead to total disruption in his occupational and personal functioning.22

The acute phase includes alcohol intoxication, the alcohol abstinence (withdrawal) syndrome, and the toxic psychoses associated with alcohol use. This phase involves the acute effects of alcohol and alcohol withdrawal, and treatment of this phase is termed detoxification. The subacute phase includes the multiple medical and psychological problems associated with alcohol use, which frequently masquerade in a more subtle (subacute) manner as disorders other
than alcoholism. The chronic phase includes such problems as social, family, and vocational ones which may have existed a priori but which are usually consequential to the alcoholism’s. Treatment during the acute and subacute phases frequently requires that physicians assume primary responsibility, with secondary responsibility assumed by non medical are providers. On the other hand, the chronic phase demands the attention of both health professionals (Psychologists, Social Workers, Counsellors) and lay persons.23

1.9 Psycho Social Aspects of Alcoholism

Family has been recognised as an important factor both in the genesis and prognosis of mental illness including alcohol and substance abuse. A strong relationship exists between family and illness. Family relationships are essentially the most important source of support that an ill person can have. While trying to provide help, close family members are more distressed and anxious than the patient. Thus rather than being of help, they may cause additional anxiety to the patient. Family members get upset if the recovery is not fast enough or if the patient develops further complication. In such conditions, generally their contention is that the person who is suffering is not making sufficient efforts to recover. Such blaming makes the patients more defensive.
Very often in Indian families men are the sole breadwinners. Once a man becomes an alcoholic, he neglects his social role as the provider of the family, compromises his prestige, loses his status and invites legal and financial consequences. The wife takes over the role. The ever enduring and self-effacing feminine prototype carried in their hearts by the wives in the Indian household does contribute to the alcoholic returning to the bottle. Moreover, an alcoholic who has got accustomed and habituated to such an over indulgence for many years from the spouse often reacts out with vengeance when she decides to do away with the providing role. This precipitates crisis in the family.

Heavy alcohol consumption exerts a deleterious effect on the family (Jacob & Leonard, 1988). The extent of the negative impact produced by the alcoholic varies among family members and from family to family. These effects on the family often result in serious emotional and medical problems. Family treatment in the field of alcoholism is a relatively new phenomenon. By the early 1970s, the alcoholic individual was viewed as a part of a family network that powerfully impacts the progression of the disease of alcoholism. Family members responses to the alcoholic’s behaviours were believed to reinforce the individuals alienation and dependency resulting from alcoholism.²⁴

Today, there are a large number of families vulnerable to various stresses and instead of being support providers they are themselves in need of support. Family members cannot relinquish their maladaptive roles unless more adaptive
behaviours are learned. In fact, the individual’s long-term sobriety may be partially dependent on the family’s replacement of maladaptive roles with more open, non defensive, and authentic ways of interacting within the system.

It has become increasingly recognised that persons from any socio-economic status can develop problems with alcohol, that these problems are not an indication of moral weakness, and that there are effective treatments for them. Excessive drinking is liable to cause profound social disruption particularly in the family. Marital and family tension is virtually inevitable. The divorce rate amongst heavy drinkers is high; and the wives of such men are likely to become anxious, depressed, and socially isolated; the husbands of ‘battered wives’ frequently drink heavily, and some women admitted to hospital because of self-poisoning blame their husband’s drinking. The home atmosphere is often detrimental to the children, because of quarrelling and violence, and a drunken parent provides a poor role model. Children of heavy drinkers are at risk of developing emotional or behaviour disorders, and of performing badly at school.

The heavy drinker often progresses through declining efficiency, lower grade jobs and repeated dismissals to lasting unemployment. There is also a strong association between road accidents and alcohol abuse. Excessive drinking is also associated with crime, mainly petty offences, such as larceny, but also fraud, sexual offences and crimes of violence including murder. Moreover, the recognition that drinking is occurring at unaccustomed times, is getting worse,
and/or is causing hardships on family and friends can cause anxious concern for
the individual. Such anxiety may result in the individual’s wanting to avoid
talking about drinking or even making excuses to cover up drinking. Also it is
difficult for people to acknowledge that they have lost control over the use of
alcohol. Such acknowledgement, however, is an important first step toward
changing the problem behaviour.

People with alcohol abuse or dependence rarely come to therapy with an
intention to stop drinking on their own accord. They are often brought by the
spouses, other family members, lawyers or employers. Motivation has long been
regarded as an important factor in treatment. “Lack of proper motivation has
been used to explain the failure to enter, continue, comply and succeed with
treatment, especially in clinical conditions like alcoholism” (Miller et al 1993)\textsuperscript{25}. Hence assessment of motivation is a key factor after detoxification for any
psycho-social interventions.

Alcoholics experiencing highly threatening or chronic psycho-social stress
following treatment are more likely to relapse than abstaining individuals not
experiencing such stress. Alcoholics report high levels of life change and abusers
who relapse report stressful experiences before relapse drinking (Hore, 1971)
and more negative life events than recovered alcoholics.\textsuperscript{26} Although stress is
often portrayed as a causal factor in alcohol relapse, the causal relations between
post hospitalisation experiences and treatment—outcome—are dynamic and
reciprocal (Finney, Moos & Mew born, 1980). Heavy or abusive use of alcohol can generate its own stress, including job difficulties, family and marital disturbances, and legal or medical problems. In fact, such major life problems are often used to define the severity of alcohol dependence.²⁷

In short, alcohol dependence is a complex disorder with far reaching harmful effects on family, work, society as well as on physical and mental health of the alcoholic himself. When we become addicted to alcohol, we make a commitment to alcohol as the foundation of our personal meaning. The authority we convey alcohol serves both sides of our existential struggle. We use alcohol to transcend our own bodies and to rise above the masses. Subject to the influence of alcohol, we experience greatness and power, attaining peak transcendent experiences. Alcohol also allows us to hide from and deny reality. The numbing glow serves to insulate us not only from the reality of alcohol’s impact on our lives, but also from our existential crises. Denial of alcoholism must be understood as a method of protecting a source of personal meaning.

When children grow up in alcoholic families, the rules (rule of rigidity, silence, denial and isolation), which are learned, become a part of the way they as adults respond to the world. They become an unconscious code of conduct because these rules are so ingrained into the children of the alcoholic family. When these children grow up, they have a tendency to search out people who follow the same rules. That’s why so many adult children of alcoholics become
involved with either active alcoholics or with people who also come from alcoholic families.

Family conflict and aversive interaction have been associated with higher levels of drug use, and problem drinking, in particular may be influenced by a breakdown in family relationships. Adolescents can be particularly susceptible to peer group influence regarding alcohol use. The relative influence of parents and peers has received considerable attention in studies of adolescent substance use, including alcohol. Alcohol dependent persons are less likely to maintain stable relationships than others, as evidenced by more frequent divorces and higher relationship distress.

Psychosocial interventions continue to be the mainstay of alcohol treatment programs. An alcoholic seeks professional help mostly persuaded by his wife, family members, neighbours, co-workers or employer. Immediate cause may be the threat of divorce, dismissal from job, a serious injury due to fall, an aborted marriage proposal to his daughter, his social misbehaviour or some health hazards.

According to Pattison and Kaufman “alcoholism is an economic drain on family resources, threatens job security, interrupts normal family tasks, causes conflict, demands adaptive and adaptive responses from family members who do not know how to respond appropriately”. Conversely, marital and family conflict may evoke, support and maintain alcoholism as a symptom, coping mechanism
and consequences of dysfunctional family styles, rules and patterns of alcohol abuse. If family changes or adapts more appropriate functions, it may sustain improvement and change in the alcohol dependent member. Hence, alcoholism has far reaching repercussions, especially on the alcoholic’s family, leading to serious consequences.²⁸

At their most basic level, non-pharmacologic approaches involve components of practice that are requisite to the successful management of any medical disorder; fostering an empathic, supportive relationship, routinely evaluating the system or problem are: providing accurate medical information about diagnosis, natural history and treatment; and following upon identified problems to improve compliance, evaluate the impact of treatment and modify treatment as indicated. Because of the nature of substance use disorders, their impact on multiple areas of functioning and the conditioned craving that occurs following repeated substance use, non pharmacologic treatments can improve outcome, even when effective pharmacologic treatments are also employed.

Behavioural treatment improves outcome by focusing on cue-evoked craving and developing effective long-term strategies to avoid or cope with craving other cues. Brief motivation approaches are particularly well suited for general medical practice settings. These approaches have been evaluated must-extensively and shown to be most effective in preventing the progression of heavy drinking to problem drinking and alcohol dependence. Following a
thorough evaluation of a patient’s drinking habits, providing advice about sensible and safe drinking to patients identified as heavy drinkers leads to meaningful reductions in drinking. For patients who have developed problems of abuse or dependence, motivation approaches can be used to foster an interest and commitment to stop use and accept a referral to treatment.

Marital and family treatment approaches have been called “the most notable current advance in the area of psychotherapy of alcoholism”, and enthusiasm derives from several sources. Many alcoholics have extensive marital and family problems, and positive marital and family adjustment is associated with better alcoholism treatment outcomes at follow up. In addition, reviews conclude that marital and family therapy have improved the results of alcoholism treatment. It is widely known that abusive drinking leads to marital and family discord, among the more serious of which are separation- divorce and child and spouse abuse. At the same time, the role-played by marital and family factors in the development and maintenance of alcohol problems is considerable. Individuals reared with an alcoholic parent are at risk for developing alcohol problems due to both genetic factors and to faculty role modelling. Marital and family problems may stimulate excessive drinking and family interactions often help to maintain alcohol problems once they have developed. Excessive drinking may provide more subtle adaptive consequences for the couple or family, such as facilitating the expression of emotion and affection or regulating the amount of
distance and closeness between family members. Even when recovery from the alcohol problem has begun, marital and family conflicts may often precipitate renewed drinking by abstinent alcoholics (Conner et al., 1998).29

**Types of Alcohol Related Problems**

<table>
<thead>
<tr>
<th>For the Drinkers</th>
<th>For the Drinkers</th>
<th>For the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accidents,</td>
<td>1. Marital Discords,</td>
<td>1. Victims of the</td>
</tr>
<tr>
<td>2. Aggressiveness,</td>
<td>2. Child Abuse,</td>
<td>Drinker-caused</td>
</tr>
<tr>
<td>3. Arrests,</td>
<td>3. Spouse Abuse,</td>
<td>accidents,</td>
</tr>
<tr>
<td>5. Withdrawal Symptoms,</td>
<td>Disorders,</td>
<td>Damage,</td>
</tr>
<tr>
<td>6. Associated medical illness,</td>
<td>Fetal damage from Maternal Drinking,</td>
<td>3. Violence,</td>
</tr>
<tr>
<td>7. Impaired working capacity,</td>
<td>Child Neglect,</td>
<td>4. Output losses (in factory, on farm, administrative inefficiency),</td>
</tr>
<tr>
<td>10. Loss of family,</td>
<td>School Drop out,</td>
<td></td>
</tr>
<tr>
<td>11. Dismissal/ loss of job.</td>
<td>Delinquency,</td>
<td></td>
</tr>
</tbody>
</table>

(Thomas Ambooken) 30
Problem drinking is implicated in most cases of violence between spouses. Financial strain, marital conflicts, social-isolation and altered interactions result in disrupted parenting, evidence by poor socialisation and lack of nurturance of children. The effects of parental alcohol dependence hamper the development of differentiation and complexity in family roles. Adolescents with alcohol dependent parents show less attachment to parents and more hostility toward parents, and they report fewer interactions among family members and less family warmth.

Family is considered as a primary care giver and basic unit for health care and medical intervention. Family support refers to emotional, instrumental and financial assistance obtained from one’s own family. Depending on the nature and severity of sickness, the family is required to mobilise its internal and external resources to cope with the impending crisis. Family relationships are essentially the most important sources of support that an ill person can have. For any meaningful intervention, it is important to identify families which have the resilience and resources to provide support.

Family intervention is a method of understanding and enhancing the role of family and family intervention is effective in decreasing hospitalisation. The ingredients of psycho-social family intervention can be summarised as (i) to build up an alliance with relatives (ii) to reduce adverse family atmosphere (iii) to
enhance the problem solving capacity of family members (iv) to decrease expressions of anger and guilt (v) to maintain reasonable expectations for patient performance. (vi) to achieve changes in the family members behaviour and belief systems. The two broad aims of the family intervention packages are to decrease tension in the family atmosphere and to improve the social functioning of the patient.

The two major forms of treatment for drug abuse, psycho-social treatments and pharmacologic treatments, have a number of differences in terms of their mode of action, time to effect, target symptoms, durability, and applicability across drugs of abuse. While each had specific indications and strengths no psychotherapy or pharmacotherapy is universally effective and both forms of treatment have some limitations, particularly when used alone. Several recent examples of the benefits of combined treatments for drug abusers are reviewed. These suggest that for many substance used disorders, outcomes can be broadened, enhanced and extended by combining our most effective forms of psychotherapy and pharmacotherapy (Najavits and Weiss, 1994)31.

As pointed out earlier, the salience of the peer group in adolescent drug use is consistent with traditional theorizing in which adolescence is conceptualised as a period during which the family and the peer group gradually exchange their respective degrees of influence. Patterson et al (1992) suggested that “family influences precede peer group influences on delinquent
behaviour. Parke et al (1988) suggested that "a bi-directional process between families and social systems outside the family reaches its peak during adolescence". For example, while peers may be the primary influence in alcohol use, the family can continue to be a moderating or augmenting source of influence throughout adolescence.

We assume that alcohol and drug use sufficient to result in hospitalisation for inpatient treatment is an enormously complex biopsychosocial phenomenon. As is true generally of cross-sectional studies, we cannot always be certain which is cause and which is effect when ascertaining, for example, personality and interpersonal variables in relation to adolescents excessive alcohol and other drug use. Alcohol and other drug use and their excessive use cannot be characterized in a straightforward manner as the result of a specific cause or causes such as the modelling of parents' or peers' alcohol and other drug abusing behaviour, alienation or psychopathology.

Alcohol problems occur within a matrix of biopsychosocial determinants and consequences. There is a dialectical relationship between excessive alcohol and other drug use, and biological, social and behavioural variables including physical and sexual abuse. Affective, intellectual, biological, behavioural and inter-personal relationships change as alcohol and drug use increases. These changes may lead to further increases in alcohol and drug abuse. Such an
interactive cycle may continue to escalate unless new factors interrupt the cycle such as the justice system, parents or a clinical intervention.

Keeping these psycho-social issues in mind, so far, attitudes toward substance abuse have generally been considered to be unidimensional i.e., positive or negative, favourable or unfavourable, in an overall, generalized fashion. Only recently factor analytic research has demonstrated that this may not be the case, and the attitudes may vary. Dismissing a composite attitude towards drinking as either ‘positive’ or ‘negative’ does not appear to do justice to the complexity of the concept (Ross and Darke, 1992)\textsuperscript{34}

According to Schuckit et.al. 1993, “the study of the natural history of a syndrome has applications in terms of its definition, the assessment of the need for, and the effectiveness of the interventions, and in teaching others about the syndrome”\textsuperscript{35}

Most controlled treatment outcome studies have reported moderately better outcomes for spouse-involved than for individual approaches. Zweben et.al; (1988) reported that “no differences in outcome between advice and couples therapy”. Most couples treatment studies also have been limited by a short follow-up window.\textsuperscript{36} A longer window of follow-up is necessary in order to evaluate the stability and pattering of changes over time. “Drinking outcomes are most variable in the first year after treatment, suggesting the importance of at least one year of follow-up” (Emrick & Hansen, 1985)\textsuperscript{37}
1.10 Evaluation and Management

Magnitude of alcohol related problem warrants a comprehensive management program and it needs to be tackled by a multidisciplinary team. Assessing alcohol dependence forms an important part of the overall assessment of a patient with alcohol problem. The measurement of the degree of dependence allows the therapist to plan treatment goals. The dependence level will indicate the severity of withdrawal during detoxification and might also provide some initial indication of how intense the treatment program needs to be. Detailed evaluation of the patient is the cornerstone of the management. The management of a person abusing alcohol needs a variety of social, psychological and pharmacological inputs. None of these can be taken in isolation of the other, and all these together contribute to the overall management of a patient. Hence, a multi modal approach incorporating pharmacological and psychosocial modalities of treatment has become the mainstay of management of alcohol related disabilities. Drugs have a role in various stages of this process, though in isolation their role may be limited in determining the prognosis of behavioral disorder that is alcoholism. Behavioral management principles and social support crucial in non-pharmacological management continue to be of importance in pharmacological management also. (Carroll and Schottenfeld, 1997). 

The present study was selected to assess the impact of family intervention therapy in alcoholism during the six months and one year follow up period. The
The purpose of the study is to highlight the importance and efficacy of family intervention therapy when combined with pharmacotherapy.

References


11. K. C. Premarajan, M. Danabalan, R. Chandrasekaran, AND


15. Ibid, Vol. 43.

16. Ibid., p. 174

17. Ibid., Vol. 65.

18. Ibid.
19. Ibid., Vol.57


