Chapter 1

INTRODUCTION

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1.1 INTRODUCTION

1.1.1. Beginnings of Alcohol Abuse

World discovered alcohol many thousands of years ago through its natural occurrence in decaying fruit or fermenting bowls of grain, in which, air-borne yeasts and natural sugars combined. Though the discovery of alcoholic drinks may have been accidental, man soon learned how to deliberately produce it. Alcoholic beverages became common, virtually in all cultures.

We are not sure where and when man discovered that carbohydrates could be fermented into alcohol. But it is known that beer was made from barley in ancient Sumeria in 6000 B.C. Societies have long venerated and feared alcohol. Ancient Egypt and Mesopotamia allowed liquor into temple rites but regulated its use (Nelmark & Conway, 1994).

The use of fermented liquor or plant products like opium, coca leaves, cannabis etc. to escape from unpleasant features of life, can be traced back to very ancient times. The earliest recipe ever found from more than 5000 years ago in the region that is modern Iraq was not of food but for beer (Carson & Butcher, 1998).

Ancient Babylonian tablets describe the process of making beer from malted barley. Wine making started with the Egyptians (Encyclopedia Britannica, 2003). Romans recognized the difference
between people who drank too much by choice and people who could not control their drinking.

All humans seem to have a need for occasional altered consciousness in social gatherings or for spiritual purposes. But negative effects were also known. Hence all cultures developed rules about acceptable and unacceptable intoxication (French, 2000, Heath, 1995).

1.1.2. The Prevalence of Alcohol Abuse

Intake of alcoholic beverages was gradually diverted from religious to ordinary use in very early times (National Institute of Alcoholism, 1993).

Man has learned from his own experience as well as from those of others that the use of alcohol and other drugs does more harm than good. But the number of people using and abusing alcohol and other similar substances increases day by day.

For some it may be that these substances are considered to have some initial beneficial effects. For others it may be because they have a tendency to indulge in something that is considered generally as not beneficial. Still some others may not consider alcohol and other substances as detrimental to health. Many people’s knowledge and attitude towards these substances are interwoven with facts and fiction, truths and half-truths, beliefs and myths.
Nelmark (1994) asks: “What other substance has so mesmerized and polarized us as alcohol?” It has a long and illustrious role in culture, from social lubricant to lethal intoxicant. There are those who content that culture itself owes its existence to alcohol, around which the first primitive, agricultural societies sprang up, with the farming and ferment of hops. Experts advocate a glass or two of wine daily, on account of wine’s healthy antioxidants and significant potential to reduce heart disease. Yet the same experts call for a sharp reduction in alcohol consumption.

Alcohol and drug abuse problems today are on the rise. Addiction knows no boundaries. Regardless of age, sex, occupational status, family background and education, it affects people in every walk of life. The disease burden is strongest in poor people (Rhen, 2009). Widespread hike in alcohol consumption among all social groups, misuse of prescription drugs and abuse of illicit drugs are causes of great concern.

According to National Survey on Drug Use and Health (2002) 51 percent of Americans aged 12 or older reported being current drinkers of alcohol. 22.9 percent of persons aged 12 or older participated in binge drinking at least once in the 30 days prior to the survey. Heavy drinking was reported by 6.7 percent of the population aged 12 or older.

The prevalence of current alcohol use increased with increasing age in 2002 from 2 percent at the age of 12 to 6.5 percent at the age of 13, 13.4 percent at the age of 14, 19.9 percent at the age of 15, 29 percent at the age of 16 and 36.2 percent at the age of 17. The rate reached a peak of 70.9 percent at the age of 21.
Addiction to alcohol and other drugs is a complex problem determined by multiple factors including physiological, psychological, social and cultural components.

1.1.3. **Alcoholism, a Great Menace to Humanity**

Alcohol addiction and drug abuse affect practically every area of abuser’s life. It is a prevalent and chronic behavioral health problem, which increases the risk for a number of other serious medical conditions. It interferes with educational and job prospects. It leaves emotional scars on the users—the scars of shame, guilt and fears of future. It weakens family relationships, emotional closeness and warmth. It weakens socialization. Socialization gets limited to alcohol or drug-abusing peers. The addict comes close to losing regard and respect for others.

Alcohol and drug abuse leads to loss of millions of human lives through accidents, homicides, suicides and the diseases caused by alcoholism. One in twenty-five deaths and five percent of years lived with disability are attributable to alcohol consumption (Rhen, 2009). It drains away the financial resources of individuals, families and nations.

1.1.4. **Alcohol Abuse in India**

The situation in India is not very different. Though India is generally considered as an abstinent country, the use of alcohol is reported throughout the history.
Distilled alcoholic beverages have been known in India since very ancient times. It formed part of the ceremonial and sacrificial rites in the Vedic age and narcotic products of hemp plant were mostly used for medicinal purposes (Hassan, 1922).

Hindu Scripture Vedas, which are believed to have been written before 2000 B.C., mentions a drink called ‘Soma’ made from the juice of different plants (Muller, 1921).

Two types of intoxicating drinks, the ‘Ira’ and the ‘Masura’ were widely used in the Dravidian times. It is also reported that Dravidians also knew the art of tapping toddy (Dikshitar, 1951).

As mentioned above, ‘Soma’, a kind of fermented liquor was in use during Arian or Vedic period. It was made of the juice of plants like ‘Hemp’ and ‘Ephenda’.

According to Ray (1906), three kinds of liquors, namely, ‘Gouri’, ‘Madvi’ and ‘Paishtri’ were known at the time of Manu. They were prepared from molasses, sweet flowers and rice and barley cakes respectively.

Liquor use was known during the time of Maurya and Sanga period, as well as in the Epic periods. The Buddhist, Muslim and Sikh traditions are seen to impose various sanctions against the use of liquor but all the same their use was never reduced.
A new trend in alcohol consumption was initiated with British colonization. Use of alcohol was widespread during the British regime.

Mahatma Gandhi was an ardent advocate of prohibition during pre-independence time. He is reported to have 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 cut down all toddy palms” (Gandhi, 1937).

In 1947, when India became independent, a strong movement against alcoholic beverage distribution and consumption developed throughout the country. Prohibition was laid down in the Directive Principles of State Policy in Indian Constitution. Since independence the Central as well as many State Governments passed laws of prohibition. Two states namely, Bombay and Madras, introduced abstinence laws by 1951. Other states also passed similar laws.

However we see a subsequent shift in the approach of the Government. The shift in Indian alcohol policy started from 1960’s that resulted in a sharp increase in the production of liquor (Mohan & Sharma, 1995). A study by Deb and Jindal (1975) in the state of Panjab shows a prevalence rate of 74.2 percent increase in alcohol consumption. According to the study of Gangrade and Gupta (1978), drinking was prevalent among 10.4 percent of the working class families. The study by Advani, Sharma, Sundaran and Mohan (1981) indicates that, the percentage of alcohol users among high school students was identical with that of the university students i.e., 12.7 percent. An interesting feature of Indian alcoholic consumption is that
alcohol use is mainly a male prerogative. It has been estimated that 40 to 50 percent of the male population drink alcohol as compared to less than 1 percent of female adults (Chandrasekhar, 1998).

The contemporary increase of alcohol use in India is due to the influence of western culture and globalization. According to Hindustan Times (December, 2003), between 15 to 20 percent of Indians consume alcohol and over the past 20 years, the number of drinkers has increased from one in 300 to one in 20.

According to a survey by Arora (2003), the state of Kerala stands first in per capita consumption of liquor, namely, 8.3 liters. From 1986 to 2003, the people who drink alcohol increased by 6 percent.

The current Government policies seem to promote alcohol consumption by making it readily available. Most Indian state governments are ambivalent about prohibition. This is mainly because alcohol is a major source of revenue for Government.

1.1.5. Treatment for Alcoholism

Declaration of alcoholism as a disease by World Health Organization (W.H.O.) is a landmark in the understanding of the phenomenon of addiction and alcoholism in particular. It left aside the moral considerations about the problem. The alcoholic is no more to be condemned or punished. He is to be treated. Alcoholism is a destructive condition, but it is potentially treatable.
Varieties of programmes to combat addiction are conducted by United Nations through United Nations International Drug Control Programme (U.N.D.C.P.). Government of India gives financial and technical support De-addiction Treatment cum-Rehabilitation Centres so that the treatment is made totally free of cost to the patients. In the state of Kerala itself there are 20 de-addiction treatment centres assisted by the Ministry of Social Justice and Empowerment under the Government of India.

De-addiction treatment facilities are available in the leading hospitals besides treatment centres specifically for the purpose.

De-addiction treatment is generally effective. A good percentage of patients when they come out after completing the treatment start leading a drug-free or alcohol free life. Even in those who relapse, a sharp reduction of alcohol use is seen. Though a complete abstinence is desirable, reduction of the abuse is also advantageous.

The problem with the treatment for alcoholism is that of relapse. Many begin to relapse after a period of abstinence. Hence it is essential to know what leads to relapse and what helps to remain abstinent.

In addiction treatment there are different strategies. With regard to alcohol and drug abuse, people within a community can be described as belonging to three different categories comparable to three zones of a traffic light. People in the ‘red zone’ are those persons who are actual addicts. People in the ‘amber zone’ are the early users, who may not be having actual problems but who are at the great risk of developing
problems. People in the ‘green zone’ are those who do not use drugs presently.

People in the red zone require expensive treatment including detoxification and rehabilitation. Those in the amber zone need proper identification and referral to treatment centres. Green zone strategies include awareness and education.

Addiction treatment has also different dimensions. It is different from the treatment for other health problems. Just as there are biological, physiological, psychological, sociological and cultural dimensions in the etiology of alcohol dependence, treatment also should include these dimensions.

Regarding the prospects of treatment, both under estimation and over estimation are to be avoided. Pessimism about the possibility of recovery would mean that no intervention is possible at all. Overestimation of the prospects of addiction treatment would be unrealistic.

There are different estimates of treatment effectiveness in terms of percentages of those who remain abstinent and those who relapse. According to William R. Miller (1994) a binary classification into “success” (abstinent) and “failure” (relapses) would be overlooking the great amount of improvements in patients who may not maintain perfect abstinence.
However the primary goal of alcoholism treatment is to help the patient achieve and maintain long-term remission of the disease. For alcohol dependent persons, remission means the continuous maintenance of sobriety. As Enoch Gordis (1989), the director of U.S. National Institute on Alcohol Abuse and Alcoholism remarks, preventing relapse, therefore, is the fundamental issue in alcoholism treatment today.

Modern science, both biological and behavioral, has explored a number of different leads in the quest to prevent relapse. These include pharmacological agents such as serotonin and disulfiram on one hand, and behaviour constructs such as cue extinction and skill training on the other. Though these are promising leads that may improve significantly the chances of persons treated for alcohol disorder to continue in long-term sobriety, there are no definite answers so far to this troubling aspect of alcoholism treatment.

Both the claims of effectiveness of serotonin to diminish the alcoholic’s craving or desire for alcohol and the efficiency of behavioral approaches to sustain the well-being should be confirmed by adequate controlled experiments.

The experience and wisdom of many alcoholism treatment personnel who are caring, competent and dedicated will continue to be key ingredients in alcoholism treatment. At the same time, new treatment technologies and techniques will have to be sought. It is highly important that treatment providers stay abreast of new developments.
1.1.6. Current Trends of Researches on Treatment for Alcoholism

Alcoholism treatment providers have to apply the results of research in their programs and practices. Today’s treatment method is not the last word in any discipline. For any disease, our hope is that tomorrow’s treatment will be better than today’s (Gordis, 2005).

Some of the focuses of current researches in alcoholism treatment are Alcoholics Anonymous, stress management, social support, religion and spirituality.

Since many years, doctors and other health care professionals started to be concerned about the effect of social support on recovery rates and prevention among their patients. Study after studies were undertaken by physicians and medical sociologists regarding the effect of social support on health. Researchers on alcoholism have shown unprecedented interest in Alcoholics Anonymous (A.A.). This is because A.A. has for long been the most widely sought form of help for alcohol problems. Treatment professionals frequently recommend that alcoholic patients become associated with self-help organization, namely, Alcoholics Anonymous, in the period, prior to, during and after treatment.

Another area of current research in intervention of alcoholism disorder is the role of stress in alcohol indulgence and impact of stress management in dealing with addiction. As Brady and Sonne (1999) have remarked, “in future, individualized treatment approaches that emphasize stress management strategies in those patients in whom a
clear connection between stress and relapse exists will become particularly important”.

A fresh and genuine interest regarding the impact of the relationship of the physical, mental, emotional, social and spiritual facets of our lives is evolving. Research is needed to unveil the possible benefits, advantages and phenomena of employing religion and spirituality in treatment and recovery from alcoholism and substance abuse. Health outcomes cannot be left solely to conventional organic medicine and the reliability of a patient’s conduct. Sharon J. Turner (2000) assumes a brave stance that “spirituality is the core of any recovery.”

Various aspects of relapse and abstinence are found included in different studies. But not many comprehensive studies are found to have been conducted, especially in Indian context to unveil the different factors leading to relapse and those favoring abstinence.

It is in this context that the present study is undertaken.

1.2. STATEMENT OF THE PROBLEM

The Problem under investigation has been stated as:

PSYCHOSOCIAL FACTORS FACILITATING ABSTINENCE IN ALCOHOLIC PATIENTS
1.2.1. Significance of the Study

Any study on alcoholism, investigating the causes and factors contributing to alcohol indulgence and suggesting measures to control the menace, will be beneficial to the society. Here the main thrust of the study is on relapse and abstinence following treatment for alcoholism.

Ultimately the success of alcoholism treatment depends on the reduction of relapse rate. According to Enoch Gordis M.D., (2005), the Director of U.S. National Institute on Alcohol Abuse and Alcoholism, approximately 90 percent of alcoholics are likely to experience at least one relapse over the four-year period following treatment. There is a growing concern among clinicians regarding the high rate of relapse among their alcohol dependent patients. Thus relapse is the central issue of the treatment for alcoholism.

The present study has both clinical and practical considerations. Clinically this study is meant to increase the awareness of practitioners, counselors and other alcoholism treatment personnel and social workers working with the alcoholics. It is important to know what are the factors that help the alcoholics to remain abstinent and those leading to relapse.

Awareness of the key ingredients for abstinence would help the efforts of alcohol treatment personnel to maximize the potential benefit of treatment for their patients. The addicts can be trained to make a strong foundation for abstinent life-style in the treatment setting itself. They could be trained to foresee the risk factors leading to relapse and foster the factors favoring abstinence. An understanding of the role of
family, friends and other support groups, in assisting the patients to lead to a healthy style of life, can be incorporated in Family and Group therapies.

From a practical point of view it is expected that the results of the study would provide information that will give practical guidelines to the treatment providers, social workers, general healthcare workers, alcoholics’ family, friends, religious groups and other support persons and the society at large. Understanding of the positive role of social support will help the family, friends and support groups to be better supportive to the addict. Understanding of the positive role of follow-up efforts in favoring abstinence will enable treatment personnel and social workers to efficiently pursue the efforts. Government authorities and public policy makers can also benefit by incorporating the findings to foster healthy way of life while drafting policies and programs of public health.

Lastly it is hoped that the results of the study will enable the addicts themselves who are struggling hard to remain sober. For, it is the victims themselves that are ultimately confronted with surrendering the old ways of thinking and acquire new healthy ways of living.
1.2.2. The Objectives of the Study

The objectives of the study were:
1. To identify the major psychosocial factors that help alcoholic patients to abstain.
2. To find out the role of stress tolerance in helping alcoholic patients to abstain.
3. To find out the role of spirituality and religious beliefs in contributing to abstinence in alcoholic patients.
4. To study the positive effect of affiliation to self-help and support groups like Alcoholics Anonymous in abstaining.
5. To study how social support helps alcoholics to abstain.
6. To study the role of certain family factors in the development of alcoholism and relapse after treatment for alcoholism.
7. To make concrete suggestions and recommendations for relapse prevention.
8. To study the role of family background in leading to alcoholism and relapse after treatment.
9. To study how follow-up efforts by the treatment agencies are helpful to the alcoholic patients to pursue an alcohol-free life.
1.2.3. Hypotheses

Pursuant to the above objectives and the review of literature that follows, the following hypotheses were formulated for investigation:

1. There will be significant differences between alcoholics who have relapsed and those who remain abstinent, in stress tolerance, perception of social support, affiliation to Alcoholics Anonymous, and spirituality.

2. There will be significant positive inter correlation among the variables stress tolerance, social support perception Alcoholics Anonymous affiliation and spirituality in the relapsed alcoholic patients, the abstinent alcoholic patients and the non-alcoholics.

3. There will be significant differences among the various categories of subjects classified according to educational qualification, marital status, separation from spouse, financial debt and father’s alcoholism in their stress tolerance, social support perception and spirituality.

4. Both the abstinent and the relapsed groups of alcoholics will differ significantly from the non-alcoholic group in stress tolerance, social support perception and spirituality, denoting the permanent character of alcohol dependence.
1.2.4. Variables of the Study.

The researcher has direct experience of working as counselor in a De-addiction Treatment cum Rehabilitation Centre. He used to encounter large number of alcoholic patients struggling hard to remain abstinent. In the regular meetings of Alcoholics Anonymous the members explain what has enabled them to remain abstinent. This has helped the researcher to form some vague idea regarding the variables. Review of research studies points to similar direction. But we cannot be conclusive about them. They need to be scientifically studied.

Hence following were the variables selected for the study.

A. Stress tolerance
B. Social support perception
C. Alcoholics Anonymous affiliation
D. Spirituality

1.3. The Plan and Procedure

1.3.1. The Sample

The sample for the study consisted of 150 persons. It included 50 patients treated for alcohol disorder and remained abstinent for more than one year and 50 patients treated for alcohol disorder and have relapsed. They were selected from patients treated at different De-addiction Treatment Centres. For comparison, 50 non-alcoholic persons were also selected. The age of the subjects was between 20 and 60.
Four cases -two subjects who relapsed and two subjects who remained abstinent after treatment-were selected for in-depth study.

### 1.3.2. Tools for Data Collection

The following standardized measures were used for data collection.

1. Stress Tolerance Scale
2. Social Support Perception Scale
3. Alcoholics Anonymous Affiliation Scale
4. Spirituality Scale

A General Data Questionnaire also was used to get pertinent information regarding various socio-demographic features of the subjects their alcohol dependence, its treatment, abstinence and relapse.

### 1.3.3. Procedure

The tools were administered individually to the subjects selected for the study. The response sheets were scored as per the instructions given in the manuals. Consolidated data sheets for the scores of the standardized scales and for the general data were prepared. The raw scores were entered in the data sheets. These were used for analysis with appropriate computer programmes.
1.3.4. **Statistical Analysis**

The data were analyzed using t test, Pearson r, Analysis of Variance and Duncan’s Analysis.

1.3.5. **Organization of the Report**

The report of the investigation is presented in six chapters. An introduction to the topic, the problem for the study, along with a brief statement of the hypotheses, the variables, the sample and the procedure are presented in Chapter 1. Chapter 2 explains briefly the concepts, characteristics, stages, effects and the etiology of alcoholism; the treatment for alcoholism and the problem of relapse. A detailed review of related researches in the topic is presented chapter 3. Chapter 4 gives a presentation of the methodology followed. Chapter 5 deals with the results, the statistical analysis and interpretation of the results. The summary, the important results, implications of the study and suggestions are presented in chapter 6.