Chapter 1

Introduction
INTRODUCTION

A ‘cup that cheers’ has been eulogized for its many virtues by statesmen, philosophers, poets and writers but it 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 Russel, a teetotaller denounced drunkenness as ‘temporary suicide’ and the happiness it brings as ‘negative and momentary’.

ALCOHOLISM

Alcohol addiction is a compulsive need for an intoxicating liquid that is obtained from fermented grain or fruit. These liquids include beer, wine, and other hard liquors. Alcoholism is present when a person craves alcohol and cannot limit or contain his or her drinking. If someone experiences withdrawal symptoms such as nausea, sweating, shakiness or anxiety when alcohol consumption has ceased, or if there is a need to drink greater amounts of alcohol in order to feel a high, that person is most likely an alcoholic.

According to the National Council for Alcoholism and Drug Dependence (NCADD) "Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial."

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 Organization’s (1952) official definition reads in part, ‘Alcoholics are those excessive drinkers whose dependence on alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health’.

Alcoholics can be of any age, background, income level, social or ethnic group. Several studies even showed that people who lack motivation are less likely to become addicted to alcohol than highly motivated individuals.
ALCOHOLISM IN THE PAST

The use of fermented liquor and other intoxicating drugs in India dates back to ancient times. The point that intoxication and drug use have never been alien to Indian culture is highlighted by Charles Simmond in his book “Alcohol, its production, properties and applications”, where he mentions that distilled alcoholic beverages have been known in India since 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 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 Varma, 1971). ‘Soma’ was terrestrial deity, the libation of which was regarded as specially sacred. The drink was extracted from the juice of plants that grows on the ‘Mujavat’ peak of the Himalayas and its use was restricted to religious ceremonies. The importance of ‘Soma’ can be realized from the fact that the entire chapter IX of the Rig-Veda has been dedicated to it (Majumdar et al., 1986).

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).

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. Jahander Shah (1712 – 1713), the grandson of Aurangazeb spent 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.

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 pot still distillation and the starting of
commercial production for revenue purposes. 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, as 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.

**PREVALENCE OF ALCOHOL CONSUMPTION**

Alcohol dependency is seen as the world's highly prevalent public health problem and therefore alcohol dependency is a matter of serious concern not confined to any group, culture or country. It is a complex disorder with physical, psychological and social aspects having far reaching harmful effects on the individual, family and society. Alcohol consumption is one of the ancient and complex disorders known in the history of mankind. It is an illness that adversely affects the life of the individual as well as the lives of those around them.

Despite modernization of nearly 60 percent to 70 percent of the South East Asia region societies are agrarian in nature and a majority of the population is either middle class or poor as per economic assessments. Given the poor socio economic status of many communities especially in rural areas, a disproportionate amount of family income is spent on alcohol, very little money for food, education, housing, health and other needs.

India is known to be 'Dry Culture'. However alcohol in some form has always existed in the country throughout the ages. Due to the significant ethnic diversity in the country, the understanding of alcoholic problems, concepts, criteria and cultural acceptance are different from the western world and vary in different parts of within the country.

**Indian Scenario**

People may drink or use drugs to escape stress, sadness or depression to appear confident or to numb the feelings of guilt, shame, anger or loneliness. 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 with a per capita consumption which is higher than the national average (8.3 litres in 1994) is perhaps
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second only to Punjab in the country (Kumar, 1992). Liquor consumption in India is estimated to be growing at 1.5 percent per annum (Chakravarthy and Rattanami, 1995). The unrecorded alcohol consumption in India is estimated to be 1.7 litres pure alcohol per capita for those above age 15 for the years after 1995, estimated by a group of key alcohol experts.

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 in Tamil nadu arrived at an estimate of 26 percent to 50 percent of men as being alcohol users. A survey of alcohol use in Madras city by Ponnudurai et al., (1991) estimated the prevalence to be 16.67 percent of the male population.

High prevalence rates have been reported for industrial workers in Punjab where Gargi and Goyal (1992) reported that while 60 percent of them were alcohol users, many of them were only recreational users. Industry association sources estimate that 15 to 20 percent of absenteeism and 40 percent of accidents at work are due to alcohol (WHO Global Status Report on Alcohol, 2004). Alcohol use among industrial workers is increasing and this has led to an increase of alcohol-related problems at work places. A study looking at the prevalence and associations of hazardous drinking was significantly associated with severe health problems, such as head injuries and hospitalizations (Chagas, 2003)

Hospital admission rates are fair indicators of alcohol abuse prevalence rates in a community. From 120 out-patient 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 (Issac, 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.

The Vedic scriptures of Indian origin have documented the use of ‘Soma Sura’ as early as 2000-800 BC in India. Even the ancient Indian texts of Charaka and Sushruta (around 300 AD) make distinctions between normal and excessive drinking
Alcohol use and the problems associated with it are on the increase in India that has the second largest population in the world with 33 percent of its population consuming alcohol. The prevalence rate of alcohol use alone is 36.5 percent.

In a community based study (Gururaj et al., 2004) in 4 areas – rural, semi rural, slum, and urban, habitual alcohol users accounted for 9 percent. Specific population surveys of alcohol use that have been carried out in India includes population such as school students, industrial workers and medical personnel that ranged between 10 percent and 60 percent. It was observed that in accordance with the growth of alcohol consumption all over the country, the hospital admission rates due to the adverse effects of alcohol consumption are also increasing. Several studies indicate that nearly 20 to 30 percent of hospital admissions are due to alcohol related problems in health care settings.

The estimate of the numbers who consume alcohol in the country was 8.9 crore with an assumption that 17 percent of males use alcohol and 85 percent of them are dependent on it. Around 4 percent of the adult male population is estimated to be alcohol dependent and there is an emerging crisis of hazardous drinking in over 20 percent of adult population (Benegal, 2005).

ALCOHOLISM – THE DISEASE CONCEPT

The rationale behind the disease concept is that like any other clinical illness, alcoholism has an etiological 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 labeled 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 behaviour.
Several researchers have defined 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-addiction centres 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 World Health Organization (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.

CHARACTERISTICS OF ALCOHOLISM

Primary Disease

Initially, alcoholism was considered as a symptom of some psychological disorder. Now it has been understood that alcoholism is a disease, which causes mental, emotional and physical problems. These associated problems cannot be effectively dealt with, unless alcoholism is treated first.

Progressive Disease

If it is not treated, the disease progresses from bad to worse. Sometimes there may be intermittent periods where one feels there is improvement, but over a period of time, the course of the disease will only be towards deterioration.

Terminal Disease

A person drinking excessively may die due to some medical complication like cirrhosis or pancreatitis. But on close scrutiny, it is found that the complication itself is induced by alcohol. Thus alcohol is the real agent behind the person’s death.

Treatable Disease

The disease cannot be cured, but it can be successfully arrested, with the help of timely, appropriate and comprehensive treatment. Treatment aims at total abstinence from alcohol. Ingestion of even a very small amount of alcohol will lead the person to obsessive drinking within a few days and he will lose control. In other words, an alcoholic can never go back to social drinking, even if he has remained sober for quite a number of years. Hence alcoholism is considered a permanent disease.
RISK FACTORS

People of all ages, income levels and living conditions can have alcohol related problems. Nearly 14 million have a drinking problem. Risk factors that may lead some people to addiction include, (AMA, 1999)

- Substance use by parents or other family members
- Substance use by peers
- Use of alcohol, tobacco or other drugs at an early age
- Physical or sexual abuse
- Abuse or violence at home or school
- Low income.

Men and women may use alcohol for different reasons. Men tend to use alcohol to feel more important and powerful. Women tend to use alcohol to fight feelings of hopelessness or anger. Children are often the most vulnerable in families with alcohol problems. Anxiety caused by the lack of a routine, feelings of guilt or shame, and absence of healthy role models and lifestyles may create problems that last through adulthood.

CLASSIFICATION OF ALCOHOLISM

Jellinek (1960) has classified alcoholism 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

Jellinek (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 drunkenness. Addiction progresses to physiological dependence and he may show grandiose behaviour, aggressiveness and develop problems with the family, work spot, friends and may develop health problems. He may attempt periods of abstinence or change his drinking pattern in this stage.

Phase- IV: The Chronic Phase

He may develop loss of tolerance to alcohol and small amounts get him severely intoxicated. He may go on prolonged, unplanned drinking spree’s lasting for several days, showing ethical deterioration and intellectual impairment. Medical complications such as liver cirrhosis, brain damage and gastric complications may manifest in this stage.
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 an overview of various theories and models pertaining to the etiology of alcoholism.

Physiological and Biological Theories

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.

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). 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 Theory

Hypoglycemia caused by pituitary-adrenocortical deficiency (Gross, 1945) and hyperthyroidism (Richter, 1978) have been implicated as causal factors in alcoholism. However, controversy exists whether endocrinal dysfunction is more the effect rather than the cause of alcoholism.

Genetotrophic Theory

According to this theory 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 (1961) describes an alcoholic as an ‘adult suckling’ suffering from oral under development. 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. Intrapyschic 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), dependency (Blane, 1968), negative self-image, feelings of isolation, insecurity and depression (Irwin, 1968; Weingold et al., 1968; Wood and Buffy, 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.

Socio-Cultural Theory

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 faculty role models for children to imitate. Situational crisis such as loss of job, death of spouse and marital instability may precipitate heavy drinking when an individual’s normal coping mechanism fails to deal with the accompanying stress. Heavy alcohol consumption
may occur in response to changes in one’s social environment that creates aversive stress, this excessive drinking in turn is further deterioration of social adjustment, creating even greater stress and perpetuating the alcoholism process.

**Multivariate Approach**

None of the theories mentioned earlier have been adequate by themselves 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 an integrated model propounds that, an individual who (1) responds to alcohol in a certain way, perhaps physiologically determined by experiencing intense relief and relaxation, 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 as well as confusion regarding what kinds of drinking behaviour are appropriate, to develop a problem with drinking.

**ALCOHOL RELATED PROBLEMS**

Developing countries like India experience more alcohol related problems than developed countries. Although conclusive scientific evidence for alcohol related health and social problems is lacking for India, there are enough indications in the available literature to infer that these are substantial. Women’s sanghas participating in women health empowerment training in several districts in Karnataka have consistently said that the biggest problem they face is related to alcohol abuse. Community health groups in different parts of the country also recognize the importance of the problem. The rapid rise in alcohol consumption in recent years has increased the likelihood of further growth of various health problems in the years to come.

**Health Problems**

- Cirrhosis of the liver and premature death
- Cardiomyopathy
- Cancer of the upper gastrointestinal tract
- Pancreatitis
- Cognitive impairment or neuro psychiatric disorders
- Road traffic accidents and injuries
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- Nutritional deficiencies and infections
- HIV infections and STD
- Hypertension

Violence and Crime

Violence within and outside the home is frequent in India and a substantial proportion of it is alcohol-related. Wife beating and child abuse under the influence of alcohol are common, street brawls and group violence happen often after drinking.

Work-place Problems

Heavy drinking affects work performance in a number of negative ways. When compared to their sober counterparts, drinkers are more frequently absent, less efficient, have more accidents at work, and also show maladjustment with other workers which leads to overall decreased performance.

Economic Problems

Besides the money spent on alcohol, a heavy drinker also suffers other adverse economic effects. These include reduced wages (because of missed work and lowered efficiency on the job), increased medical expenses for illness and accidents, legal cost of drink-related offences, and decreased eligibility of loans. Most individuals with severe alcohol dependence find it difficult to reduce their expenditure on drinks and hence their families often must do without essential necessities.

Family Problems

Excessive drinking by a family member results in several negative consequences for others in the family, especially for the wife and children of a male drinker. These effects are particularly serious for poor families. As mentioned above, much of the family income may be used to buy alcohol, wages may decline, and the drinker may eventually lose his job. In such a situation the wife and children are forced into work, often in low paid, hazardous jobs. Wife and child battering are common, which lead to physical and mental trauma. Failure of the man to use contraceptive methods often leads to unwanted pregnancies, further increasing family size. These factors contribute towards greater poverty, often to the point of destitution. Strong family ties and social disapproval of divorce save many of these families from a formal breakdown, but the prevalence of intermittent or prolonged marital separation, as well as suicide, in heavy drinking families is high. Problems faced by the wives of alcoholic
men have been studied scientifically by many researchers, but the descriptive accounts by the lay press offer more vocal testimony of these phenomena. It is also found that wives of alcoholic men show a high degree of depression.

**Marital Problems**

Initially the focus of research was on the behaviour of the person with alcohol dependency. Gradually the realization has come in that it is the family particularly the spouse, who bears the impact, of husband’s alcoholism in and who is being caught up in the pathology of the alcoholic’s disease process developing parallel emotional and behavioural problems. This has shifted the focus of attention to the spouse.

An association between alcohol abuse by husband and spouse abuse or divorce has been noted in many studies. It has also been reported that drinking accompanied 44 percent of cases of women abuse. The behaviour of married alcoholic can cause so much disruption in his marital life that there is reported association between alcoholism and divorce. However divorce is not always the outcome in many cases, wives tolerate and the degree of tolerance or acceptance of alcoholic’s aberrant behaviour on the part of his wife may vary widely depending on the culture and pattern of the society.

The National Healthy Marriage Resource Centre (NHMRC) investigated the marital problems, which arise due to alcohol abuse by the partner. The following are the various marital problems faced by the spouse.

**Marital Satisfaction and Quality**

- **Marital distress** - Alcohol abuse increases the feelings of marital distress. Individuals in marriages in which one or both spouses is an alcoholic, report higher levels of marital distress than do married individuals who are not married to alcoholics.

- **Anger** - Marital satisfaction is related strongly to a couple's ability to communicate effectively. But heavy alcohol use is associated with more negative and hostile communication, more expressions of anger, and less warmth and unity in the relationship. These factors decrease a couple's satisfaction in their marriage and create greater tension.

- **Everyday family responsibilities** - Alcohol abuse decreases marital satisfaction because it decreases the drinking spouse's ability to participate in everyday
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household tasks and responsibilities. This inability leads to greater stress on the non-drinking spouse and decreases satisfaction in the marriage.

- Psychological distress - Alcohol abuse increases the psychological distress of the non-drinking spouse. An adult's alcohol abuse is also related to children's' increased social, emotional, behavioural, and academic problems, which in turn, leads to more stress in the family and less marital quality.

Marital Communication

- Damaging communication - With alcoholism and marriage, alcoholic spouses tend to use more negative and damaging communication (e.g., criticizing, blaming, contempt), express more anger, and show lower levels of warmth when trying to solve a problem than do non-alcoholic spouses. This kind of negative communication discourages the use of positive problem solving skills such as open discussion and encouragement.

- Less problem solving - Couples in which one partner is alcoholic engage in problem solving less often than do other couples. Partners in such marriages may lose the desire to engage in problem solving and give up when alcohol is involved because they anticipate that the conversation will soon become negative. As this pattern continues with alcoholism and marriage, important issues such as family finances, sexual intimacy, and child-rearing decisions go unresolved because it is easier to avoid communicating than to deal with the stress and negative emotions that are associated with alcohol-related communication problems.

- Personality characteristics - Personality characteristics common among alcoholics also can affect communication. Alcoholics tend to be less conscientious, less agreeable, more anxious and hypersensitive than the nondrinkers. These personality characteristics make effective communication and problem solving more difficult.

- Effects on the brain - Researchers believe that alcohol's effect on the brain may contribute to the increase in negative communication. Alcohol appears to impair a person's ability to understand and properly interpret what a spouse is saying. Alcoholics tend to interpret things their partners say in a very negative way and this leads them to respond with greater anger and negative emotions.
**Marital Violence**

- Among battered women, 40-60 percent reported that their husbands were heavy or problem drinkers. Among married men admitted to alcohol treatment centres, 50-70 percent reported participating in partner violence, with 20-30 percent of these men reporting having engaged in severe violence towards their spouses.

- The more frequently men are intoxicated, the more likely they are to be verbally and physically violent toward their spouses. Alcohol abuse is connected to increased aggression and marital violence that tends to be more severe and more likely to result in injury.

- Spouses under the influence of alcohol tend to act more aggressively, perhaps because their ability to think rationally is reduced. Alcohol tends to make individuals more impulsive and to decrease their ability to restrain their aggression. This pattern is especially noticeable among spouses who are more aggressive even without alcohol.

**Sexual Problems**

- It has been observed that women being intolerant of alcohol leads to severe conflicts between the couples. As a result the wife shows her inability to respond to her husband’s sexual advances. Another observation made was that, some wives refuse to co-operate with their recovered alcoholic husbands. They have lost their sexual feelings because of forced sexual abstinence when their husbands’ were engaged in excessive drinking.

**CONCEPTUAL FRAMEWORK**

Alcoholism creates a vicious cyclical relationship, which seemingly damages the families of alcoholics. The alcoholic family unit is being viewed as a system of interaction between the marital partners. The influence of the husbands’ alcoholism generates a crisis in the family and disturbs its equilibrium. The husbands’ alcoholism may result in a change of spousal interaction patterns, and alters the complexion of the domestic environment by taxing the resources of the family resulting in dysfunction in several areas. The immense stress experienced by the wives in dealing with the pressures of the alcoholic husbands’ drinking behaviour is likely to influence their marital life experience.
Alcohol exerts great influence on couple dynamics. In fact, it has been estimated that alcohol affects a minimum of four other persons, with family members most commonly affected (National Institute of Alcohol Abuse and Alcoholism, 1981).

Figure 1. Conceptual Framework

Figure 1 presents a schematic representation of the conceptual framework of the present study and the area of present investigation. Various researchers have acknowledged that alcoholism influences and is influenced by marital/family processes (Kenneth Leonard and Rina Eiden, 2007). It is also presumed that abusive levels of alcohol use have been associated with marital violence (Leonard and Jacob, 1988). Continuous exposure to conflict situations force the wives to manage their conflict situations tactfully. Bauserman, Arias and Craighead (1995) have reported that daily problem drinking and marital conflict can be dealt by using coping strategies that influence the acceptance or tolerance of the partners drinking. But inability to cope up with the stress leads to frustration and this annoyance is reflected on the
communication pattern between the couples as well as within the family circle. Previous studies suggest that alcohol abuse is the causative factor for the withdrawal of interactions within the family resulting in an increased psychological distress. Such increased psychological distress, and the drinking spouse's inability to participate in everyday household tasks and responsibilities, leads to a greater pressure on the non-drinking spouse and decreases the quality in marriage. As the marital quality decreases, the wives experience loss of support and confidence in dealing with issues concerning their marriage; this loss of self-assurance affects their quality of life. But it should also be accepted that in spite of having poor quality of life the wives of alcoholics, try to handle various conflict situations in an improved way.

Thus, the present study is based on the simple premise that husbands' alcoholism influences the study marital dimensions of the spouse. Further it is assumed that the selected marital factors are influential upon one another and affects the overall marital life of the wives of alcoholics.

**ALCOHOLISM – A FAMILY DISEASE**

Alcoholism is also known as a family disease. Alcoholics may have young, teenage, or grown-up children, they have wives or husbands, they have brothers or sisters, they have parents or other relatives. An alcoholic can totally disrupt family life and cause harmful effects that can last a lifetime. According to the United States Department of Health and Human Services, seventy six million adults have been exposed to alcoholism in the family.

Most "typical" alcoholics are married with jobs and family responsibilities. Alcoholism is an illness that consumes the entire family. The feelings, thoughts and actions of everyone in the family are affected by the alcoholic's drinking. Family members cannot control the alcoholic's drinking but they can control its effects in their lives.

**TYPES OF ALCOHOLIC FAMILIES**

People who grow up in alcoholic families have common symptoms and behaviours as a result of their common experience. It is these shared symptoms and behaviours that are exhibited by the adult children of alcoholics (ACoAs) apart from other people. They view the world in a way that is unique. The alcoholic family is a family in which the disease of alcoholism has affected the way the family system
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operates. The influence of the disease invades all aspects of family life and the family operates in a way that is basically unhealthy. The difference between the alcoholic family system and healthy system is that the alcoholic family system operates in a way that limits and controls the actions and emotions of the individual members. The healthy family operates to allow the individual freedom of expression and freedom of growth. There are four types of alcoholic family systems. The following is a description of each type of system.

Type 1

This system is riddled with active alcoholism. In children, parents, grandparents, great grand parents and even further back the family history, active alcoholism is rampant. Every generation of this family will have both active alcoholism and adult children of alcoholics’ issues to deal with.

Type 2

In this system the actively drinking member of the nuclear family has stopped drinking. Although the active alcoholism has been arrested, the family system will continue to operate in a way that can only be described as alcoholic. It is important to note that even when the alcohol is removed from the system, if the family remains untreated, the alcoholic behaviour will continue to operate. Many ACoAs who come from this type of system feel a great deal of conflict.

Type 3

In this type, the active drinking has been removed from the family for one or more generations. In this system, the parents did not drink in the alcoholic way, but one of their parents or even grand parents were alcoholics. Even though active drinking has not been in the family for some time, the family dynamics continue in a way that is still characteristic of an alcoholic family. Many ACoAs come from this type of family. Their parents did not abuse alcohol, but one or more of their grandparents did, and their family continues to follow the rules and behaviours of an actively drinking alcoholic family.

Type 4

In this non-alcoholic family one of its members becomes an alcoholic. The family then becomes an alcoholic family. The family becomes more and more dysfunctional in its attempts to deal with the alcoholics’ behaviour.
When looking at the four major types of alcoholic families, it is important to consider two things. First, the effects of alcoholism on the family occur even when the active drinking is not present. Second the alcoholic system will recreate its generation after generation if the family is not treated.

RULES OF THE ALCOHOLIC FAMILY

There are four general rules that operate in the alcoholic family. These rules are

1. Rule of Rigidity
2. Rule of Silence
3. Rule of Denial
4. Rule of Isolation

The chart below shows that the core of every alcoholic family is the disease of alcoholism.

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<thead>
<tr>
<th>Rule of Rigidity</th>
<th>Rule of Silence</th>
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<tbody>
<tr>
<td>ALCOHOLISM</td>
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<tr>
<td>Rule of Denial</td>
<td>Rule of Isolation</td>
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1. **Rule Of Rigidity**

The alcoholic family is inflexible. It cannot adapt to change easily nor does it willingly allow family members to change. One of the effects of alcoholism on an individual is unpredictable behaviour. As the alcoholism progresses, the behaviour of the alcoholic becomes increasingly unpredictable. As the family adapts to the alcoholic's increasingly unpredictable behaviour, it becomes increasingly rigid. Because of its rigid structure, the children in the system are not allowed to grow emotionally. When these children become adults they are in most cases still children, emotionally.
2. **Rule of Silence**

Members of alcoholic families are bound by a rule of silence. They cannot talk about what is happening in the family. This rule of silence extends not only to talking to people outside the family, but also includes talking to the members of the family itself. This rule of silence not only bans talking about the behaviour and actions of the family, it also bans talking about feelings. This no talk rule is so strong that children who grow up in this family system have difficulty in expressing themselves for the rest of their lives. This rule follows them and they in turn teach it to their children.

3. **Rule of Denial**

The denial of the alcoholic family begins with the denial that there is any problem with alcohol. As the behaviour of the family members become more and more dysfunctional, the denial becomes stronger and stronger. Denial is one of the cornerstones of the system. If the system can continue to deny what is happening, then it will not have to change. This denial also extends to feelings. When painful events occur, the feelings that naturally accompany those events are denied because they are not 'supposed' to have these feelings.

4. **Rule of Isolation**

The alcoholic family is a closed system. It resists the movement of its members in and out of the system and resists adding outsiders as members. The members cling emotionally to each other, but never become intimate. The alcoholic system tries to be self-sufficient. It creates the myth that no one outside the system will understand and that no one outside the system is to be trusted.

**ALCOHOLIC FAMILY AND HEALTHY FAMILY – A COMPARISON**

The alcoholic family and the healthy family are at the opposite ends of the spectrum. The alcoholic family operates in the way that contains and controls the members of the system. This control stifles the mental, emotional and sometimes physical growth of its members. The healthy family on the other hand assists its members in their development. The controls that the healthy family places on its members are appropriate to the age group and the abilities of the individual members.
Table 2

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Alcoholic Family</th>
<th>Healthy Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Rigid rules</td>
<td>No rigid rules</td>
</tr>
<tr>
<td>2.</td>
<td>Rigid roles</td>
<td>No rigid roles</td>
</tr>
<tr>
<td>3.</td>
<td>Family secrets</td>
<td>No family secrets</td>
</tr>
<tr>
<td>4.</td>
<td>Resists outsiders entering the system</td>
<td>Allows outsiders into the system</td>
</tr>
<tr>
<td>5.</td>
<td>Is very serious</td>
<td>Has a sense of humor</td>
</tr>
<tr>
<td>6.</td>
<td>No personal privacy, unclear personal boundaries.</td>
<td>Members have right to personal privacy and develop a sense of self</td>
</tr>
<tr>
<td>7.</td>
<td>False loyalty to the family members is never free to leave the system.</td>
<td>Members have a sense of family and are permitted to leave the system.</td>
</tr>
<tr>
<td>8.</td>
<td>Conflict between members is denied and ignored</td>
<td>Conflict between members is allowed and resolved</td>
</tr>
<tr>
<td>9.</td>
<td>The family resists change</td>
<td>The family continually changes.</td>
</tr>
<tr>
<td>10.</td>
<td>There is no unity, the family is fragmented</td>
<td>There is a sense of wholeness.</td>
</tr>
</tbody>
</table>

The following chart shows how alcoholism affects the family members with the same intensity with which it affects the dependant person

Table 3

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Behaviour / Feelings</th>
<th>Of the Patient</th>
<th>Of the Family members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Preoccupation</td>
<td>Waits for the earliest opportunity to use alcohol</td>
<td>With the behaviour of the chemically dependant person. 'My God what is this person going to do next'</td>
</tr>
<tr>
<td>2.</td>
<td>Loss of control</td>
<td>Over the quantity, time and place of drinking</td>
<td>Over her own responses and behaviour</td>
</tr>
<tr>
<td>3.</td>
<td>Avoiding any talk about the chemical</td>
<td>Diverts any talk pertaining to chemicals</td>
<td>Gives instructions even to her children to keep alcoholism a family secret.</td>
</tr>
<tr>
<td>4.</td>
<td>Justifying</td>
<td>Justifies his drinking habit</td>
<td>Justifies her own irresponsible attitude and the family holds the alcoholic responsible for each and every problem in the family</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Aggression</strong></td>
<td>Verbal / Physical abuse</td>
<td>Throws temper-tantrums sometimes anger becomes misplaced</td>
</tr>
<tr>
<td></td>
<td><strong>Denial</strong></td>
<td>Denies the ‘problem’ totally or justifies his misbehaviour by holding others responsible.</td>
<td>Totally denies the problem or denies the fact that some problems in the family are the results of her own irresponsible behaviour.</td>
</tr>
<tr>
<td></td>
<td><strong>Low self worth</strong></td>
<td>Feels unworthy and low</td>
<td>Always feels inadequate, with low self esteem</td>
</tr>
<tr>
<td></td>
<td><strong>Guilt</strong></td>
<td>At times feels guilty about his own behaviour and makes promises to change.</td>
<td>Wonders whether her inadequacy is the reason behind his abuse.</td>
</tr>
<tr>
<td></td>
<td><strong>Ethical breakdown</strong></td>
<td>Begs, borrows or steals to maintain his supply of alcohol.</td>
<td>Takes away money from his pocket so that he will not be able to buy alcohol</td>
</tr>
<tr>
<td></td>
<td><strong>Indefinable fear</strong></td>
<td>Afraid that everyone around is going to harm him.</td>
<td>Afraid of even minor events, experiences, constant lurking fear due to her internalized emotional stress.</td>
</tr>
<tr>
<td></td>
<td><strong>Dishonesty</strong></td>
<td>Utters all sorts of lies to 'hide' his alcoholism</td>
<td>Tells lies to cover up the consequences of alcoholism. Utters lies even when it is not necessary. It becomes an adaptive response.</td>
</tr>
<tr>
<td></td>
<td><strong>Acute depression</strong></td>
<td>Caused by excessive / inappropriate use of alcoholism (Consequence of the toxic effects of the drug on the central nervous system)</td>
<td>Due to loss, frustration and helplessness</td>
</tr>
<tr>
<td></td>
<td><strong>Is a victim</strong></td>
<td>Of Alcoholism</td>
<td>Victimized ‘By Alcohol’ even though she is not using it</td>
</tr>
</tbody>
</table>

**IMPACT OF ALCOHOLISM IN THE FAMILY**

The nature and extent of impact of alcoholism in the family can be described under three main headings namely financial, social and emotional.
Financial Impact

Alcohol has a worst impact on the financial situation in the family, especially the lower income group. Whatever is earned is spent on drinking and the needs of the family members are not met. There will be no savings. The wife may be compelled to take up a job to support the family financially and this adds to her responsibilities. Sometimes, even the eldest child may be forced to take up a job. Drinking often leads to debts. The drinker may even go to the extent of selling family properties and wife’s jewels to satisfy his thirst for alcohol. These affect the family adversely, both physically and mentally.

Social Impact

Alcoholism gradually, but invariably leads to social isolation. It is not merely the alcoholic who finds himself isolated, but his family as well. As far as the family is concerned the process of isolation begins due to a tendency on their part to avoid people, this is because the family members suffer from a sense of shame and embarrassment. The wife avoids accompanying the husband to parties and other social gatherings because she cannot bear the tension of never knowing when her husband will begin to misbehave due to drunkenness. She cannot face the pity and comments. Gradually people in turn begin to avoid them. The isolation gets worse. For example, no one will be prepared to rent their house to a known alcoholic. Society wishes to have nothing more to do with someone who is judged irresponsible and weak in every sense of word.

Emotional Impact

Alcoholism cripples the family emotionally. The intensity and nature of emotional impact depends upon the depth of the drinking problem, the character and the personality of the alcoholic and vulnerability to criticism from ones’ socio-economic circles. The problem faced by the family members intensifies as the financial security lessens. The wife reacts to her husband’s alcoholism either by mutely accepting her ‘fate’ or by throwing temper tantrums, sulking, losing her temper or walking out on her husband for a brief while. The various emotional responses of the wives are:

1. Guilt

Most wives tend to harbour guilt feelings about their husbands’ drinking problem. They feel that it is some deep inadequacy in them that forces their husband to
drink. Therefore by making martyrs of themselves, they try to hold onto a melodramatic position in order to prevent their self-confidence from dwindling further.

Guilt of this proposition cannot be sustained or tolerated. Therefore in the course of time each starts blaming the other, and this illusion prevents both the partners from developing self-awareness that might lead to a positive change.

2. Grief

The family has lost all the pleasures of life. For the family members, grief is the result of loss of family prestige, loss of family and personal dignity, loss of feelings of love, loss of care and understanding, loss of security, loss of friends, loss of each and every area of life. Beyond all this they do not share their feelings with anyone. They need someone to listen to them as they pour out their grief, someone to help them to shift their feelings from the dependent person towards their own self.

3. Anger

The family members experience anger and deep sadness. Initially this anger is focused towards the addict and his inappropriate behaviour. As the disease worsens the wife or parents feel helpless and this makes them more angry. Their anger does not have any focus at all. They are angry with themselves, with their husband even when he is not drinking, with their children, friends and society. In short their anger is directed towards the entire world at large.

4. Hurt

If anger is suppressed within a person, it automatically results in frustration, resentment and hurt feelings. As the harmful dependency progresses, his inappropriate behaviour can no longer be hidden. At every point the family members feel humiliated. It hurts to become involved in unnecessary arguments or witness angry exchanges.

5. Shame

Most of the painful experiences resulting from chemical dependency brings a lot of shame to the family members. The inappropriate behaviour of the addict in front of friends makes the family terribly embarrassed. As the situation worsens, shame multiplies and the person starts feeling ashamed of the entire family. Shame produces low self worth in each and every member of the family.
6. **Fear**

Living in problematic distressed family produces fear of future, fear of the family life, fear of financial matters, fear about the dependent’s physical well-being, fear about his drunkenness and a persistent fear that nothing is going to become normal. Even minor events cause lot of tension. These feelings of fear are the result of the internalized emotional stress which each individual family member experiences.

7. **Loneliness**

The stressful situation in the chemically dependant’s family results in the breakdown of normal family communication. The isolation created by lack of communication always leads to bitter loneliness. The family members talk a lot, but they never communicate with a purpose, they never share their feelings or emotions with each other. They do not communicate with others around them. As a result they are always alone.

8. **Denial**

As fear increases the family members experience a denial of the whole problem. Denial is an unconscious defense mechanism used without conscious knowledge or thought to control fear and anxiety. Family denial normally takes two shapes

a. Family denies the existence of the whole problem whatsoever and gives excuses such as ‘going through a stage’, ‘too much pressure’ etc

b. The family acknowledges the problem, but empathically declares that the problems are limited to the dependent person. They believe that the chemically dependent person has been responsible for each and every problem in the family.

**CO-DEPENDENCY**

The concept of Co-dependency emerged from the traditional alcoholic field. Initially, wives of alcoholics had negative names as Provocatrix, Controlling Catherine, Suffering Susan, Wavering Winnie and PUNITIVE Polly referring to the neurotic enabling role that they presumably play in their spouses’ behaviour. Gradually less judgmental terms such as Co-alcoholic, Para-alcoholic and finally Co-dependency was used to describe all members of any family with a chemically dependent member.

Co-dependence is considered to be a disease entity to substance addiction except in this case the sufferer is addicted to or preoccupied with a relationship with
another person instead of a mood altering substance. Co-dependence as generally defined is thought to involve one’s sense of identity, purpose, worth and security or significant others and perceiving their needs, wishes, thoughts and feelings more important than their own. It is characterized by hyper vigilance to interpersonal cues that is so compelling that it over shadows self-awareness and sense of responsibility for others that is so great that care taking of others supersedes self-care.

Concept of co-dependency describes that in spite of facing continuous abuse, spouses may continue to stay with the alcohol dependent person. Other perspectives like the socio-cultural perspectives have criticized the concept of co-dependency as this concept deviantizes certain interpersonal behaviour as addictive, pathological and devalues feminial valued behaviour and caring and empathy.

Feminist critics have pointed out that co-dependency pathologizes, privatize and depoliticizes relationship problems that are rooted in larger socio-cultural patriarchal structures. Women usually stay in bad relationships for economic and child related reasons and not because they are neurotic or co-dependent. The powerlessness that is falsely called Co-dependency is the reality of survival in the alcoholic home.

ROLES TAKEN UP BY THE SPOUSE

As the problem worsens, the spouse takes on various roles to cope with the situation.

Protector

Person is the primary enabler. She wants to show care and concern for the chemically dependent person and she wants to protect her own dignity. So she takes on the role of an ideal wife who is able to manage everything without any support. This, in turn makes life easy for the chemically dependent person. He continues with his abuse. She continues to protect him, support him, apologize for his mistakes and find excuses for his drug abuse. She is not even aware that it is this role adopted by her that enables him to continue with his irresponsible behaviour and inappropriate use of alcohol.

Controller

The spouse attempts to control the alcoholic’s drinking habit by adopting methods like hiding, emptying or breaking the bottle, pleading with the alcoholic not to
drink during day time, asking him to drink only at home and not outside. The more the wife tries to control her husband, the less fruitful her efforts become. With a vengeance, he starts drinking more and more and the situation becomes worse.

**Blamer**

Now, the wife is totally frustrated and helpless. This leads to anger, bitterness and resentment towards the alcoholic. She starts blaming the husband for each and every problem in the family and starts neglecting her duties. This leads to total disorder in the family.

**Loner**

As the chemical dependency progresses, the spouse experiences inappropriate mood swings. She goes into deep depression and indulges in hours of lonely crying or violent outburst of anger. She wants to be left alone. She avoids visiting even their friends and relatives.

Thus Alcoholism has negative effect on the families especially on the spouse of an alcoholic. The spouse may have feelings of hatred, self-pity, avoidance of social contacts, she may suffer exhaustion and become physically or mentally ill. Very often the spouse has to perform the role of both parents. Family responsibilities shift from two parents to one parent. As a result, the non-alcoholic parent may be inconsistent, demanding, and often neglect the children. A survey, “Exposure to Alcoholism in the Family”, conducted in 1988 suggested that alcoholism is a major factor of premature widowhood. Alcoholism is also one of the major reasons for divorce.

**CHILDREN OF ALCOHOLICS - (AcoAs)**

A child who is raised in an alcoholic family develops a set of characteristics. These characteristics are grouped into four categories.
### Table 4
Characteristics Grouping Chart - ACoAs

<table>
<thead>
<tr>
<th>Emotional Characteristics</th>
<th>Mental Characteristics</th>
<th>Physical Characteristics</th>
<th>Behavioural Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear, anger, hurt, resentment, distrust, loneliness, sadness, shame, guilt and numbness</td>
<td>Thinking in absolute, lack of information, compulsive thinking, indecision, learning disabilities, confusion, and hyper vigilance.</td>
<td>Tense shoulders, lower back pain, sexual dysfunction, Gastro intestinal disorders, stress related behaviours, and allergies.</td>
<td>Crisis oriented living, Manipulative behaviour, Intimacy problems, Unable to have fun, tries to fit in compulsive addictive disorders</td>
</tr>
</tbody>
</table>

### STATE OF THE CHILDREN OF ALCOHOLICS

A) **Three painful self-imposed rules in the home of an alcoholic**

The children of alcoholics are governed by three unwritten rules.

1. **Don't Talk**

   These children never share or talk about anything which happens at home. Any chaotic situation at home like shouting, crying or beating will never be discussed with friends, teachers, relatives or even with their own brothers and sisters. This is because they are always given subtle instructions that they should not disclose their father’s excessive drinking and drunken behaviour to any one, not even to their grandparents. Others behaviour also strengthens their conviction that it is wrong to disclose what happens at home. This will affect the sense of pride and the image of the family they are expected to protect.

2. **Don't Trust**

   Children of alcoholics find it difficult to develop trust because the behaviour of their parents is inconsistent and unpredictable. The alcoholic father and the non-alcoholic mother make lot of promises but never bother to keep any of them.

   ‘I will take you to a movie this evening’
   ‘I will buy you a new dress’

   But none of these things ever happen. The declaration next morning will always be, ‘I will do it later not now’, but the ‘later’ never comes and therefore all turn
out to be lies. So the message to the child is ‘forget it – do not believe anyone – do not trust anybody’

3. **Don’t Feel**

In an alcoholic home, nobody ever recognizes or appreciates any of the feelings expressed by the children, these children learn to repress their feelings. This they learn from parents who refuse to deal with their own emotions, and from the criticism and ridicule they often receive when they try to express their own feelings. These children learn that the expression of feelings will be met with disapproval, hostility or rejection. In order to avoid this punishment, they learn to suppress their feelings. In other words they train themselves not to feel.

**B) Self-protection Roles taken by these Children**

Any child longs for protection and love. The children of alcoholics have no one to care for them, no one to understand their feelings. Therefore to fulfill these emotional needs, they discover ‘ways of being’ (roles) that assure them of protection. Their role always takes the focus off their alcoholic father and place it on themselves. Some of these roles establish a balance for them amidst the confusion and offer the outside world a positive message reflecting a family image they are expected to protect.

1. **The Responsible Child**

The Responsible child takes over the responsibility of the parents. This child provides stability in the family and makes life easier for the parents by looking after the other siblings. This child is very organized and goal oriented. He is adept at planning and manipulating others to get things done. He is often independent, self-reliant and capable of achievements and accomplishments. But because these accomplishments are not made out of choice, but out of a necessity to survive, there is usually a piece paid for this ‘early maturity’

The responsible child becomes the ‘Family Hero’ and begins to feel responsible for the family pain. They never enjoy the pleasures of childhood. Even minor failures cause a lot of depression in them. They never experience the warmth and love of parents and do not know what emotional dependence means.
2. **The Adjusting Child**

The Adjusting child learns to adjust and handle any situation. This child finds it easier not to question, think about or respond in anyway to what is happening in life. Adjusters do not attempt to change or prevent any situation. They simply adjust – that is do what they are told. They detach themselves emotionally, physically and socially as much as possible. The adjuster becomes a ‘Lost Child’ and suffers loneliness when he grows up. He has no zest for life. He is always afraid to take risk because of his fear of being hurt. Such children when they grow up become the victims of manipulation of people around them. They may result in ending up with stress related illness.

3. **The Placating Child**

The ‘Placator’ goes one step beyond the ‘Adjuster’. He anticipates the problems of others around him and tries to help them out, unmindful of getting hurt in the process. The child assists his brother in not feeling hurt or disappointed. This child intervenes and ensures that none of the children are too frightened after a ‘screaming scene’ at home. The Placator becomes the ‘Family Mascot’. He is often cute, fun to be around, and able to use charm and humor to survive in a painful family system. The child is so preoccupied with the needs of others that he forgets to take care of his own. As a result his unmet needs get accumulated and he is no more able to carry the burden. He is unable to give up the mask of self-control and happiness, he feels desperate and suffers through his life.

4. **The Rebellious Child**

Some children of alcoholics become angry and aggressive at an early stage. These children become the ‘Family Scapegoats’ and are branded as troublemakers. Youngsters in the family normally assume this role. These children try to satisfy their parents by resorting to positive methods. As they never get attention from them, they finally resort to negative ways, which will not escape their notices. They defy authority and get into trouble at home, indulge in fights and quarrels at school and even with their neighbours. These children end up as rebels, show delinquent behaviour, throw temper tantrums and drop out of school. They smoke and as a pat of bravado even experiment with drugs or alcohol and sex.
TREATMENT

A variety of alcoholism addiction treatment options are available to address the physical and psychological components of the disease. The first step in breaking the addiction is to seek the counsel of a healthcare provider and/or addiction therapy specialist who has the expertise to make an evaluation and design a treatment program, based on the individual needs.

Like all addictions, treating alcohol dependence is complex and there is no one-size-fits-all formula to facilitate recovery. To successfully recover from an addiction, external treatment is usually necessary and often includes different treatment approaches to achieve positive outcomes and sustain long-term management of the disease. Depending on circumstances, treatment may involve one or more of the following: Interventions through counseling, residential program, outpatient program, medication and/or ongoing support program participation.

Interventions

Brief interventions may be utilized when alcohol consumption is abusive or dangerous to the drinker, or those around him or her. Goals typically include:

- Moderating drinking activity
- Establishing specific behavioural goals
- Building necessary skills to change drinking behaviour

Interventions usually consist of one to four counseling sessions by a trained interventionist who may be a doctor, psychologist or social worker. Strategies such as motivational interviewing are used to persuade resistant individuals who do not believe their drinking is harmful or hazardous.

Residential Programs

Residential or inpatient alcoholism addiction treatment programs provide medical detoxification, in-depth therapy, and education to rehabilitate the alcohol-dependent individuals. The treatment often include both individual and group counseling, structured physical activities, nutritional counseling, stress reduction, holistic approaches such as yoga, saunas, acupuncture and neuro-feedback, vocational training, relapse prevention support, social skills training, educational services and 12-step substance abuse programs.
Program duration varies from one week to few months, according to the needs of the individual. The environment is highly structured and medical professionals are available around the clock. Inpatient treatment most often benefits alcoholics who have not succeeded in outpatient programs, who lack healthy social networks and/or suffer from serious physical or mental health conditions from consumption.

Outpatient Programs

Outpatient alcoholism addiction treatment programs enable individuals to receive treatment without staying overnight in a rehabilitation facility. An outpatient approach may be recommended in place of residential options or designed to serve as maintenance therapy after inpatient treatment is completed. For this reason, the duration, intensity and type of outpatient programs vary significantly. Some feature daily 8-hour treatment sessions, while others may have individuals attending for a few hours for three or more days or evenings a week. Treatment typically includes a combination of drug and behavioural education, individual and group counseling, and educational support for caregivers.

Medication

Medication has played an increasing role in recent years and is sometimes prescribed to complement and propel other treatment initiatives. While taking medicine, will not help overcome alcoholism (or any addiction), three drugs have shown promise in supporting overall treatment efforts and have received approval by the U.S. Food and Drug Administration.

Disulfiram: serves as an alcohol deterrent. Individuals on the drug experience severe reactions such as facial flushing, throbbing headache, nausea, vomiting, heightened blood pressure and increased heart rate when consuming alcohol. Even tiny amounts of alcohol can cause unpleasant effects.

Naltrexone: reduces the urge to drink by blocking neurotransmitters in the brain that produce the "high" people experience when they consume alcohol.

Acamprosate: helps by reducing the physical distress and emotional discomfort (i.e. sweating, anxiety, sleep disturbances) people usually experience when they stop drinking.
These medications can only be prescribed to people who have already stopped drinking and have undergone or are receiving therapy. They are of no use if individuals are still consuming alcohol; there is no silver bullet to help someone stop drinking. The effectiveness of these drugs is directly tied to the alcoholic’s motivation to stay sober and get well. Therefore, the benefits vary by individual and can only support alcoholism recovery goals when used in combination with therapy and support group engagement.

**Peer-Support Programs**

Peer support groups such as Alcoholics Anonymous, Smart Recovery, Secular Sobriety, Women for Sobriety and others help alcoholics discuss and address their addiction in a non-threatening community that provides encouragement, support and a social outlet.

In addition, there are online support groups for alcoholism addiction treatment that are available 24 hours a day, seven days a week. Each self-help organization offers a slightly different philosophy and approach – yet all focus on abstinence-based recovery and a well-defined set of principles for peer support. Involvement is voluntary and meetings take place on a regular basis. Participation in addiction support groups may follow residential or outpatient treatment and is often used in conjunction with different types of therapy and/or medication.

**PROHIBITON STEPS TAKEN BY GOVERNMENTS**

Politicians have for long continued to play ducks and drakes with liquor policy and successive governments both at the central and in the states have never had a consistent approach. On 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 – 1995 taxes on liquor contributed a revenue of Rs. 18000 crore to state exchequer 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 population 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.
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 outlets and the status continues to this day.

The Expensive prices of IMFL and the non-availability of cheap country liquor have pushed the thirsty lower class into the clutches of easily available illicit liquor. This has often resulted in huge tragedies in the past. Prohibition then whether total or partial may not be the right approach in dealing with alcoholism. An article on ‘Prohibition’ in the Illustrated weekly of India states that our aim should be ‘temperance not total abstinence; persuasion not prohibition’. This observation seems relevant even today.

CONCLUSION

Thus alcohol use is a part of the fabric of marriage and family life, and although it is associated with certain positive effects, excessive drinking and alcohol disorders can exert a negative effect on the marital development and on the development of children in the context of the family. It affects the spouse of the drinker and in turn the wives go through lots of hardships. These suffering make them to resort to various strategies to come out of marital distress. Even with all the above facts, it is quite surprising that all that we do as remedial measures with wives of alcoholics is with inadequate knowledge. Because, still we are lacking some of the fundamental knowledge regarding the emotional aspects, self-concept, adjustmental capacity of wives of alcoholics which reveals inadequate conceptualization and methodological problems in research studies. Many works have been done on wives of alcohol dependents with regard to their personality but very few works have been conducted on their marital life. Hence the present investigation proposes to study the ‘Marital Correlates among Wives of Alcoholics and Wives on Non-alcoholics’ and the researcher explores selected marital factors namely Conflict Tactics, Proactive Coping behaviour, Family Interaction pattern, Marital Quality and Perceived Quality of Life. The intention of this study, from the social work perspective is to bring the wives of alcoholics sharply under focus in the treatment programmes.