A PROGNOSTIC STUDY OF ALCOHOLIC ADDICTION USING PSYCHOLOGICAL COUNSELLING YOGA THERAPY AND DIET THERAPY

Thesis submitted to
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award of the degree of

DOCTOR OF PHILOSOPHY IN PSYCHOLOGY

DOLLY GEORGE

DEPARTMENT OF PSYCHOLOGY
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CERTIFICATE

This is to certify that the thesis entitled ' **A PROGNOSTIC STUDY OF ALCOHOLIC ADDICTION USING PSYCHOLOGICAL COUNSELLING, YOGA THERAPY AND DIET THERAPY'** is a bona-fide research work done by **Mrs. DOLLY GEORGE** under my supervision and that it has not been submitted for the award of any other degree or diploma earlier.

Calicut University
17th May 2013

Dr. John Baby
(Supervising Teacher)
Reader (Rtd.)
Dept. of Psychology
University of Calicut

DECLARATION

I, **Dolly George** hereby declare that this thesis entitled **"A PROGNOSTIC STUDY OF ALCOHOLIC ADDICTION USING PSYCHOLOGICAL COUNSELLING, YOGA THERAPY AND DIET THERAPY"** is the original research work done by me under the supervision of **Dr. John Baby**, Reader (Rtd.), Dept. of Psychology, University of Calicut for the award of the degree of **Doctor of Philosophy in Psychology** of the University of Calicut and further that this thesis contains no material previously submitted for a degree, diploma, associate ship, fellowship or other similar title of any other University or Society.

Calicut University
17th May, 2013

Dolly George

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Dolly George

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To

My Loving
Appachan & Kunjammachi….

INTRODUCTION

INTRODUCTION

Health psychology a branch of the science of psychology can be defined as the study of psychological and behavioral processes in health, illness and health care (Johnston, M.1994). Psychological factors can directly affect health such as stress causes the release of hormones like cortisol which can damage our body gradually and indirectly through a person's own behavior choices such as smoking or doing exercise which can harm or protect health (Ogden, J.2012).

Health psychologists understand health in a bio psychosocial perspective which can be the product of not only a biological processes like a virus, tumor etc, but also of psychosocial processes like socioeconomic status, culture and ethnicity. (Ogden, J.2012).

The theory and therapy dealing with alcohol dependence syndrome come under Health Psychology which is a vast area of health related psychological variables. The present study follows a holistic approach towards the curative process of alcoholic addicts. The efficacy of psycho nutritional cure procedures is being examined in alcoholic dependence syndrome.

Substance abuse

Substance abuse or drug abuse is a patterned use of a substance (drug) or alcohol or any organic or inorganic poisons in which the user consumes in amounts or with methods which is not approved or supervised by medical professionals. Using illicit drugs like narcotics, stimulants, depressants

(sedatives) hallucinogens, cannabis, glues and paints are classified as drug/substance abuse. (Ksir, Oakley, *et.al*, 2002). Alcohol dependence syndrome comes under the area of substance abuse which includes problems with impulse control and impulsive behavior.

Substance abuse or drug abuse leads to addiction with the development of tolerance and dependence. Tolerance refers to a condition in which the user needs more and more drug to get the same effect. Some drug produces only psychological dependence but some others produce both physical and psychological dependence.

When psychological dependence develops, an emotional and mental pre-occupation with the effect of the drug will increase and a persistent craving for it will exist.

When physical dependence develops, the user's body becomes totally depended on the drug and it is able to function normally only if the drug is present.

After the user becomes dependent, and the intake of drug is abruptly stopped, withdrawal symptoms occur. To avoid the unpleasant withdrawal symptoms the person needs the drug (Alcoholism and drug dependency, 1989).

DSM IV – TR defines substance abuse as a maladaptive pattern of substance use which results clinically significant impairment or distress as manifested by one or more of the following, occurring within a 12-month period.

1. Repeated substance use resulting failure to fulfill major role obligations at work, school, or home.
2. Continued substance use in physically hazardous situations
3. Recurrent substance – related legal problems
4. Continued use of substance despite having persistent or recurrent social or interpersonal problems caused by the impact of the substance. (American Psychiatric Association)

Classification of Addictive Drugs

Addictive drugs can be classified in to five major categories based on their origin, chemical structure, mechanism of action etc. They are (1) Narcotic analgesics (2) Stimulants (3) Depressants (4) Hallucinogens and (5) Cannabis. Among these, alcohol comes under depressant group as per the professional master guide followed in Modern Medicine. (Alcoholism and drug dependency 1989).

Alcoholism

An alcoholic beverage is a drink that contains ethanol commonly known as ethyl alcohol. Alcoholic beverages are classified in to three general groups' beers, wines and spirits. Addiction to alcohol is commonly known as alcoholism. People suffering from alcoholism are often called alcoholics. According to W H O there are 140 million people worldwide with alcoholism. (Ms. Leanne, Riley. 2003).

A dual classification of alcoholism is supported by American Medical Association which includes both physical and mental components. Social

environment, stress, mental health, family history, age, ethnic group and gender all influence the risk factors. (Glavas. M. M *et.al*, 2006)

Alcoholism is characterized by an increased tolerance and physical dependence on alcohol which affects an individual's ability to control consumption safely. These factors play a role in an alcoholic's ability to stop drinking. (Hoffman, P.L, *et.al*, 1996)

Alcohol has adverse effects on mental health leading to psychiatric disorders causing depression and increasing risk of suicide. (Dunn, N& Cook. 1999)

Identifying alcoholism is very difficult because of the stigma associated with the disease. Fear of shame on social consequences makes people with alcoholism to avoid diagnosis and treatment. (Kahan, M. 1996).

Terminology

According to the Random House Dictionary of the English Language (1966), due to the excessive use of alcoholic beverages, alcoholism is defined as a diseased condition.

Alcoholics can be of any age, background and income level, social or ethnic group. Many studies showed that people who are highly motivated have more chances to become addicted to alcohol than less motivated individuals. (Silverstein, 1990).

In 1960, Bill W, co-founder of Alcoholics Anonymous (A.A), said: we never called alcoholism a disease because technically it is not a disease as there is, no such thing as heart disease. Instead there are many separate heart

ailments, or combination of them. Something similar is happening in alcoholism. Therefore we always called it an illness or a malady which is safer term to use.

AA describes alcoholism as an illness which has physical allergy and mental obsession. William. D. Silk worth, doctor and addiction specialist, writes on behalf of AA those alcoholics suffer from a physical craving beyond mental control.

In psychology and psychiatry the DSM is the most global standard but in medicine the standard is ICD. The terms they recommended are similar but not identical.

Organization	**Preferred term(s)**	**Definition**
APA's DSM-IV	"alcohol abuse" and "alcohol dependence"	• Alcohol abuse = repeated use despite recurrent adverse consequences. • Alcohol dependence = *alcohol abuse* combined with tolerance, withdrawal, and an uncontrollable drive to drink. The term "alcoholism" was split into "alcohol abuse" and "alcohol dependence" in 1980's DSM-III, and in 1987's DSM-III-R behavioral symptoms were moved from "abuse" to "dependence". It has been suggested that DSM-V merge alcohol abuse and alcohol dependence into a single new entry, named "alcohol-use disorder".
WHO's ICD-10	"alcohol harmful use" and "alcohol dependence syndrome"	Definitions are similar to that of the DSM-IV. The World Health Organization uses the term "alcohol dependence syndrome" rather than alcoholism. The concept of "harmful use" (as opposed to "abuse") was introduced in 1992's ICD-10 to minimize underreporting of damage in the absence of dependence The term "alcoholism" was removed from ICD between ICD-8/ICDA-8 and ICD-9.

A 1960 study by E. Morton Jellinek is considered the foundation of the modern disease theory of alcoholism. Jellinek's definition restricted the use of the word "alcoholism" to those showing a particular natural history. The modern medical definition of alcoholism has been revised numerous times since then. The American Medical Association currently uses the word alcoholism to refer to a particular chronic primary disease.

The common man defines alcoholism as a weakness of character. Law considers consequential acts of alcoholism as a crime. The clergyman finds it a sin.

In 1956 after an extensive research, American Medical Association came to the conclusion that it is a disease. An alcoholic is different from a social drinker. Social drinker drinks occasionally or regularly in moderate quantities. His alcohol consumption does not cause any problems in his life. But “An alcoholic is one whose drinking causes continuing problems in one or more areas of his life. (family relationship, financial position, occupation etc). In spite of these problems he will keep on drinking. This is the difference between a social drinker and problem drinker. (Alcoholism and drug dependency 1989).

Alcohol Metabolism

The metabolism of alcohol is through four phases. They are absorption, distribution, oxidation and elimination.

Absorption

Absorption takes place in the stomach and small intestine. The thinnest of blood vessels called capillaries found in the walls of the stomach and small intestine absorb alcohol soon it enters and transport it to all parts of the body.

Distribution

This is the process in which alcohol enters in the blood to each organ, tissue and cell. By diffusion alcohol leaves the blood stream and enters the cell. Then it affects the various organs including the brain.

Oxidation

After distribution oxidation process begins. Alcohol is oxidized by the liver at the rate of 8 – 15 ml per hour. The enzymes produces by the liver helps the oxidation process. Alcohol is first changed to Acetaldehyde and then it is converted to Acetate by the enzyme Aldehydrogenase. As a result of the oxidation process, alcohol is broken in to carbon dioxide, water and energy. The energy yield of alcohol oxidation is about seven kilo calories per gram of alcohol. There is a fact that exercise, fresh air, cold shower, hot bath or black coffee will have no effect on the oxidation rate.

Elimination

After oxidation these by -products re-enter the blood stream and pass to the kidneys. The kidneys filter out the end products of the oxidation process and finally excreted from the body.

Ethyl alcohol is considered a food that supplies empty calories i.e., calories without any nutritive value. (Alcoholism and drug dependency, 1989).

Pathophysiology

Alcohol stimulates the GABA receptor, and promotes central nervous system depression. With excessive heavy alcohol consumption, these receptors desensitize and reduce in number those results in increased tolerance and physical dependence. (Dart & Richard, 2003)

If equal amount of alcohol consumed by men and women its effect differ between sexes. Women are having higher blood alcohol concentration than men. (Karrol Brad, R. 2002)

The attributed reason is that women have less body water than men. Therefore a given amount of alcohol becomes more highly concentrated in a woman's body. Due to different hormone release a given amount of alcohol causes greater intoxication for women than men. (Walter, H, *et al*. 2003)

Alcohol withdrawal

Withdrawal from alcohol can be fatal if it is not properly managed, as with similar substances with a sedative hypnotic mechanism such as barbiturates and benzodiazepines. (Mc Cully, Chris, 2004, Galanter, *et al*. 2008)

If consumption is stopped abruptly, an uncontrolled synapse firing will occurs in the person's nervous system. This causes symptoms that include anxiety, life threatening seizures, delirium tremens, hallucinations shakes and heart failure. The neurotransmitter systems especially dopamine, NMDA and glutamate are also involved in it. (Hoffman. P.L. 1996)

After one week post cessation of alcohol severe acute withdrawal symptoms such as delirium tremens and seizures rarely occur. One to three weeks acute withdrawal phase can occur. Following cessation in the 3-6 weeks increased anxiety, depression as well as sleep disturbances can occur (Heilig, M .*et al*, 2010). Up to 5 weeks as part of the post acute withdrawal syndrome fatigue and tension can persist and a quarter of alcoholics suffer from anxiety and depression for up to 2 years.

A kindling effect occurs in alcoholics in which each subsequent withdrawal syndrome is more intensive than the previous withdrawal episode. This is because of neuron adaptation occurs as a result of periods of abstinence followed by re-exposure to alcohol. The individuals who have had many withdrawal episodes develop seizures and severe anxiety during withdrawal from alcohol than individuals without a history of past withdrawal episodes. The kindling effect causes persistent functional changes in brain neural circuits as well as to gene expression. (Breese, G.R, *et al*, 2011)

Causes of alcoholism

Researches in to the physiological, psychological and sociological factors has resulted in a far greater understanding of the conditions that may precede, underlie and maintain problem drinking, there is no generally agreed upon model of how alcoholism start.

The risk of the development of alcoholism influences a complex mixture of genetic and environmental factors. (Enoch, M.A. 2006). The risk of alcoholism also influences the genes that help metabolism of alcohol and may

be indicated by family history of alcoholism. (Bierut, L.J *et al*, 2000). In a research it was found that alcohol consumption in an early age may influence the expression of genes that increase the risk of alcohol dependence. (Agrawal, A. *et al*, 2009). The individuals who begin drinking at an earlier age can have a genetic disposition to alcohol than average. (Medical News Today. 21st September 2009).

If the onset of alcohol intake is in an early age that is associated with an increased risk of the development of alcoholism and about 40 percent of alcoholics will consume excessively by their late adolescence.

Severe childhood trauma is another risk factor which is associated with drug dependency. (Enoch, M.A, 2006). Lack of family and peer group support is associated with an increased risk of alcoholism. With chronic alcohol abuse an increased sensitivity to the neurotoxin effects will occur and cortical degeneration due to this effect increases impulsive behavior, which may lead to the development, persistence and severity of alcohol use disorders. During abstinence, there is reversal of some of the alcohol induced central nervous system damage is evident. (Crews, F.T. *et al*, 2009)

Physiological Theories

Some of the proposed theories are genetic, endocrine, and genototrophic theories.

Genetic theory

Some in this field theorized that alcoholism may be inherited. Alcoholism appears to run in families suggested that an alcoholism prone

individual may have inherited a susceptibility to be influenced adversely by ingested alcohol.

Endocrine theory

One major physiological theory of the cause of alcoholism indicates a dysfunction of the endocrine system. Similarities between the symptoms identified in alcoholic patients and the patients with endocrine disorders suggest that failure of the endocrine might be related to the onset of alcoholism.

Genetotrophic theory

The genetotrophic theory of alcoholism deals with the concept of genetic trait and nutritional deficiency. As a result of an inherited defect or error of metabolism, many people require unusual amount of some of the essential vitamins. While they do not get these unusual amounts from their normal diet they have a genetically caused nutritional deficiency. These people who drink alcohol develop an abnormal craving for the substance and the result is alcoholism. (Comprehensive Health Education Foundation, Here's looking at You Two – A teacher's guide to alcohol/drug abuse. 1982)

Biological studies of the causes of obsessive drinking

The way body usually deals with alcohol is the liver breaks the alcohol in to acetaldehyde, which is very toxic substance, and then it is broken down in to acetic acid which is vinegar and finally the acetic acid is broken down in to water and carbon dioxide which is eliminated through the kidneys and lungs.

When alcoholics gets a lot of alcohol in their brain tissue after heavy drinking something different occurs. A small part of the acetaldehyde interacts

with substance in the brain called dopamine to form THIQ (Tetrahydroisoquinoline). The majority of the acetaldehyde is disposed in the normal way. There is a fact that once the THIQ is formed it does not disappear even if the alcoholics stop drinking. Thus the THIQ formed in the brain is the basis of the physical compulsion to drink. (Dr. Eric Gandry, 1984)

Psychological theories

Some researchers believe that alcoholics posses a number of distinctive personality trait which make up the alcoholic personality. The approaches to the psychological causes of alcoholism are the psychoanalytic theory, the learning theory and personality trait theory.

Psychoanalytic theory

Psychoanalytical explanations come under three major theoretical positions.

- The Freudian view
- The Adlerian view
- The view that alcoholism develops as a response to an inner conflict between dependency drive and aggressive impulse.

The Freudian view expressed alcoholism to repressed urges, oral dependency, need for security self punishment and parental hatred.

The Adlerian view represents a striving for power, which tries to compensate a feeling of inferiority. Alcoholic takes alcohol to enhance his feeling of self esteem and power.

Learning theory

The learning and reinforcement theory explains alcohol ingestion as a reflex response to some stimulus and as a way to reduce inner drive such as fear and anxiety. This theory proposes that persons tend to be drawn to pleasant experiences and repelled by unpleasant or aversive ones.

Cultural theory

The cultural theory of alcoholism suggests that in a given society the culture may influence the rate of alcoholism in three ways.

The degree of inner tensions and acute needs for adjustment society operates in its members. The attitude of the culture towards drinking influences its members.

Deviant behavior theory

The deviant behavior theory represents the alcoholic as some one who publically labeled as deviant and is forced to play a deviant role by society's reaction. (Alcoholism and drug dependency, 1989).

Disease theory of alcoholism

Disease theory of alcoholism proposes that problem drinking is due to a disease of the brain caused by altered brain structure and function. Alcoholism is a chronic problem but if managed properly brain damage can be stopped and to a certain extent reversed. (Bartsch, *et al*, 2007). The symptoms of the disease include an impaired control over alcohol, compulsive thoughts about alcohol, and distorted thinking. (Morse, R.M, *et al*, 1992). Alcoholism can also cause physical dependence on alcohol, and diseases such as cirrhosis of the liver.

Genetics and Environment Theory

According to this theory genes play an important role in the development of alcoholism.

Twin studies, adoption studies and artificial selection studies revealed that an individual's genes can predispose him to developing alcoholism. Results from twin studies show that concordance rates for alcoholism are higher for monozygotic twins than for dizygotic twins (Carlson *et al*, 2005).

Adoption studies also indicate a strong genetic predisposition towards alcoholism. Studies on separated children from their biological parents demonstrate that children of alcoholic biological fathers were more likely to become alcoholic even if they have been separated and brought up by non alcoholic parents (Carlson *et al*, 2005)

Signs and Symptoms of Alcohol Dependence

People who have problem with alcoholism often

- Continues drinking even though they face problem with health, work or family
- Drink alone without any company
- More prone to violent behavior when drinking
- Become aggressive and avoid any talk about drinking
- Unable to stop or reduce alcohol intake
- Make justification to drink
- Problems at work place, school or a decrease in performance due to drinking

- ❖ Stop participating in activities because of alcohol
- ❖ To get through the day alcohol is necessary
- ❖ Neglect to eat or not eat proper food
- ❖ Do not care about their dressing or whether they are clean
- ❖ Try to conceal alcohol use
- ❖ Lack of motor co-ordination
- ❖ Memory loses after heavy drinking
- ❖ Needs more and more alcohol to feel "drink".
- ❖ Have alcohol withdrawal symptoms when not used for a while
- ❖ Alcohol related physical or psychological illness like liver disease, Paranoia etc.

(Jellinek E.M, 1960)

Long Term Effects

If alcohol used for a long time that can cause a number of physical symptoms, like cirrhosis of the liver, pancreatitis, epilepsy, polyneuropathy, alcoholic dementia, heart disease, nutritional deficiencies, peptic ulcers and sexual dysfunction and can eventually be fatal. (Leiken Jerrold *et al*, 2003)

Other physical problems include an increased risk of developing cardiovascular disease, mal absorption, alcoholic liver disease, and cancer. If alcohol consumption is sustained for a long period, damage to the central nervous system and peripheral nervous system can occur. (Muller *et al*, 1985, Testino, G. 2008)

A wide range of immunological defects that leads skeletal fragility and a tendency to accidental injury resulting bone fractures. (10th special report to the U.S Congress on Alcohol and Health. 2000)

Women get long term complications of alcohol dependence more rapidly than men. In addition to this women have a higher mortality rate from alcoholism than men. (Blume Laura, N. *et al* 1998). The long term complications include brain, heart and liver problems and an increased risk of breast cancer. (Walter, H. *et al*, 2003). In women heavy drinking over time have a negative effect on reproductive functioning, such as an ovulation, decreased ovarian mass, problem or irregularity of the menstrual cycle, and early menopause (Blaume Laura, N. *et al*, 1998)

Alcoholic ketoacidosis can occur in chronic alcohol drinkers and those who have a recent history of binge drinking.

Alcoholism: Effects on the body

Alcoholism can cause serious health issues. The health problems associated with alcoholism can range from anemia to severe problems like blood clotting, cirrhosis of the liver, or heart disease. If an alcoholic continues to use alcohol for an extended periods of time that can cause permanent brain damage and the person may die.

Earnest Noble 1978 and Antony Radcliffe 1985 in their book about alcoholism, describes the effects of alcoholism on the body. The following are the main areas in which alcohol can be affected.

Alcohol and the brain

Continuous alcohol consumption can affect ones mood and is associated with depression, anxiety and some psychological problems such as obsessive compulsive disorders, panic attack and sleep disturbances. Alcohol alters the functioning of neurotransmitters which can cause memory loss, confusion and affects sensation, perception and motor skills. Alcohol cuts the oxygen supply in the brain, and will damage the cells in the brain. Wernicke's syndrome and Korsakoff's psychosis are two such syndromes closely associated with alcoholism.

The effects of alcoholism on the stomach and esophagus

Cancers affecting esophagus and other parts of the mouth are mainly due to alcoholism. More than that alcoholism weakens the lining of stomach and esophagus which can cause vomiting and tears its tissue. Irritation of gastro intestines due to alcohol consumption can produce ulcers and erosion to its lining.

Excessive alcohol consumption leads acute gastric damage and causes gastritis. With gastritis, the person may experience bleeding, acid, accumulation reflux, and other digestive problems.

The effects of alcoholism on the intestines

Digestive problems in the small intestine are common in alcoholics. Heavy drinking leads to changes in the intestinal motility. This causes diarrhea in binge drinkers. Intestinal mal absorption can also result from alcohol consumption. Excessive alcohol consumption can cause colon cancer.

Effect of alcoholism on the heart

Alcoholism can result heart diseases including increased blood pressure, irregular heartbeats, and can lead to heart failure. Alcohol can cause strokes by raising blood lipids.

Effect of alcoholism on muscle tissue

Alcoholism can lead to muscle atrophy where the muscle tissues of the body deteriorate. Some types of arthritis are common among alcoholics.

Effect of alcoholism on the kidneys

Alcoholism can cause enlarged kidneys and results kidney failure. Another important consequence is renal failure. It happens when kidneys get overworked due to excessive intake of alcohol.

Alcohol inhibits the release of an anti-diuretic hormone which leads to excessive urination and it increases the release of body's fluids during urination. This can cause dehydration which is one of the reasons of hangovers.

The effects of alcoholism on the liver

A well known consequences associated with alcoholism is cirrhosis. It happens when liver develops too much scar tissue. Excessive alcohol consumption can cause fat deposition on the liver and finally alcoholic hepatitis.

The effects of alcoholism on the lungs

Alcohol affects the rate of respiration. Moderate level of alcohol intake increases the respiratory rate, but in large doses, rate of respiration is

decreased. Alcoholism reduces immune function which can often result in lung infections, pneumonia and collapse of a lung.

The effects of alcoholism on the pancreas

Alcoholism is associated with increased risk of pancreatitis a chronic inflammation of the pancreas. Alcohol can also lead to pancreatic cancers.

The effects of alcoholism on the reproductive system

Excessive consumption of alcohol can cause problems with the body's natural hormone production. Alcohol depresses the part of the brain that controls inhibitions and hence the person becomes less inhibited. The fact is that although sexual desire exists, sexual performance and capability are diminished.

Fetal alcohol syndrome is a disorder found in children born of mothers who excessively use alcohol during pregnancy. (Earnest P Noble, 1978 & Antony Radcliffe 1985)

The effects of alcoholism on nutrition

Malnutrition can occur as a result of alcoholism. Alcohol is a high caloric carbohydrate with no nutritive value. The more a person drinks less he eat. Alcoholics do not take enough nutrient rich calories. Moreover alcohol reduces the capacity of the body to metabolize nutrients effectively. There is an impairment in the absorption of vitamins and minerals which needed for healthy functioning of the organ. (Jerry, Kennard, 2006)

Blackout and memory lapse

Blackout is a period of temporary amnesia during the drinking days. It is different from unconsciousness. During this period the person may go through many activities like, walking, talking, even driving normally but do not remember it afterwards. Alcohol can produce memory impairments after only a few drinks and the amount of intake increases the degree of impairment also will increase. (Jellinek E.M, 1960)

Binge drinking and blackouts

Blackout usually occurs in persons who drink quickly and too much quantity hence their blood alcohol level will raise rapidly. Binge drinking is five or more drinks in about 2 hours for men and four or more drinks for women.

Psychiatric Effects

If a person uses alcohol in a long term basis it can cause severe mental health problems. Severe cognitive problems are common among alcoholics and approximately 10 percent of all dementia cases are due to alcohol consumption. Excessive alcohol use results damage to brain function and it will adversely affects the psychological health of a person. (Oscar Berman, *et al*, 2003)

Due to the neurotoxin effects of alcohol on brain social skill impairment is evident among alcoholics. Impairment in facial emotions, problems in prosody perception and theory of mind deficits and difficulty to understand humour are the main social skills that are impaired by alcohol abuse. (Uekermann J.*et al*, 2008).

Psychiatric disorders are common among alcoholics. Symptoms like anxiety and depression are more prevalent and these symptoms appear mostly during alcohol withdrawal and improve or disappear with complete abstinence. Alcohol misuse can cause psychosis, confusion and organic brain syndrome which can be a misdiagnosis as schizophrenia. (Schuckit, M.A. *et al*, 1984). Long term alcohol misuse can also cause or worsen panic disorder. (Cowley D.S. 1992, Cosci ,F. *et al*, 2007)

Depending on gender, psychiatric disorders differ. Women who are addicted to alcohol often have psychiatric problems such as major depression, anxiety, panic disorders, bulimia, post traumatic stress disorder or border line personality disorder. Men who have alcohol addiction problem have a co-occurring diagnosis of narcissistic or antisocial personality disorder or attention deficit hyperactive disorder. (Karrol Brad, R. 2002). It is also reported that women with alcoholism usually have a history of physical or sexual assault, domestic violence or abuse than normal population which results higher chances of psychiatric disorders and alcohol dependence.

Social effects

Alcohol can make pathological changes in the brain and also it can produce intoxicating effects. These two are the main causes of social problems associated with alcoholism. (Georgey Bakalkin, 2008). Most of the criminal offences are associated with alcohol abuse which includes child abuse, domestic violence, rape, assault and burglary. Loss of employment is another major problem which results financial crisis. (Langdana F.K. 2009).

Alcoholism can cause problems in judgment, and the use of alcohol in an inappropriate time can lead to legal consequences such as criminal charges for drunk driving or public disorder, or civil penalties for tortuous behavior and may lead to criminal sentence. (Gifford & Maria, 2009).

Alcoholism and its effect on the family

While drinking, an alcoholic's behaviors changes and mental impairment occurs, which affect those who are close to him and lead to isolation from family and friends. This situation can result to marital conflict and divorce or lead to domestic violence.

In an article by Tetyana Parson (2009) she explained alcoholism and its effect on the family. Alcoholism is known as a family disease. An alcoholic can totally disrupt family life and cause harmful effects that can last life time.

Chemical dependency is not an isolated problem that affects only one individual. Apart from the dependent person, the prime victims are his wife, parents and children. These people who do not drink or take drugs but are affected by chemical abuse are called co-dependents. Emotional responses of co-dependents are guilt, grief, anger, hurt, shame, fear and loneliness. The behavioral responses are family denial, protector, controller, blamer and loner. (James E Burgin, 1982).

Effects on spouse

An alcoholic's spouse may have feelings of hatred, self pity, avoidance of social contacts and also suffer exhaustion and become physically or mentally ill. (Berger, 1993). A survey conducted in 1988 about exposure to alcoholism

in the family suggested that alcoholism is a major factor of premature widowhood (Berger, 1993). Alcoholism is one of the major reasons for divorce.

Members of alcoholic's families are usually known as co-dependent. Co-dependency is an unconscious addiction process to another person's abnormal behavior (Wekesser, 1994). Co-dependents are also known as enablers. Enabler is a person who helps an alcoholic unknowingly by denying the drinking problem exists and helping the person to get out of troubles caused by his alcohol consumption. (Silverstein, 1990).

Fetal Alcoholic Syndrome

Parental alcoholism may affect the fetus even before a child is born. A pregnant woman who drinks alcohol during her pregnancy can give birth to a child with Fetal Alcohol Syndrome (FAS). (Tetyana Parson, 2009). Compared with normal babies, babies born with FAS are shorter and under weight. They have deformities of the brain and skull and small eye openings, thin upper lips, long flat faces and a long groove in the middle of their upper lips are very characteristic facial features. Due to the central nervous system damage they have difficulty in learning, attention span, judgment, memory, problem solving, and frequent behavior problems. They also suffer with social skills. Their frustration easily turns to anger as they grow older. These children are usually hyperactive. They are often impulsive, poorly coordinated and have impaired speech and hearing. Fetal Alcohol Syndrome and its effects are permanent, usually leading to lifelong problems with mental retardation. "Children of

alcoholics are people who have been robbed of their childhood". (Silverstein, 1990).

Effects on normal children

Parental alcoholism has severe effects on normal children of alcoholics. These children have problems such as low self esteem, loneliness, guilt, feelings of helplessness, fear of abandonment, introversion and chronic depression. (Berger, 1993).Parent's alcoholism can lead to child neglect which causes damage to the emotional development of the child. (Schade, J.P. 2006). Because of their parents unstable mood behavior they are afraid of their parents. The children also feel shame over their inadequacy to liberate their parents from alcoholism. Due to this feeling of failure they develop wretched self images, which can result depression. (Gold, Mark 2011). Children of alcoholics often make problems at school. The stressful home environment prevents them from studying. Evidences show that many adult children of alcoholics make company with someone who is an alcoholic or some way abusive. (Wekesser, 1994). According to Berger adult daughters of alcoholics often tend to have more reproductive problems and consult their gynecologists and obstetricians. In addition they have tendency to become bulimic.

Alcohol expectations

Alcohol expectations are the attitudes and beliefs people have about the effect they will experience when drinking alcohol. Alcohol can influence a person's behaviors, abilities and emotions. Some people believe that alcohol

abuse can be reduced by changing alcohol expectations (Grattan, Karen.E, *et al,* 2001).

A study shows if a society believes that intoxication leads to sexual behavior, rowdy behavior or aggression then people tend to act accordingly after consumption. But if a society believes that intoxication results to relaxation and tranquil behavior then it leads to those outcomes. Alcohol expectation varies within a society; hence these outcomes are not certain (Marlatt G.A, *et al,* 1981).

Dealing with denial in alcoholism

In the alcoholics, denial takes place in an unconscious level. It is a distortion in thinking experienced by alcoholics. According to Mark S Gold, denial is an integral part of the disease of alcoholism and a major obstacle to successful recovery. There will be a denial of reality, in the sense; the individual will not report accurately the frequency of intake, quantity or the problems associated with it. The level of denial will be different to each individual with alcoholism. Their level of awareness about the problem will be different and they are in different stages of readiness to change their behavior. Depending upon the severity of addiction the strength of denial varies.

Denial occurs in individual and societal level. In an individual level common forms of denial are simple denial, minimizing, blaming or projecting, rationalizing, intellectualization and diversion. In societal or family level denial occurs in the form of enabler, which is a protective behavior often motivated by love and concern. It permits the individual to continue his drinking and hence

the disease will progress. Just like denial, enabling is one of the symptoms of alcoholism, which is displayed by others not by the alcoholic. The first step in the treatment of alcoholism is overcoming denial and enabling behavior. (Gold M.S, 2006, Jon.R.Weinberg, 1980)

Screening

To identify an alcoholic several tools are used. Most of the tools are self reports in questionnaire form. Another one is a tally or score that sums up the general severity of alcohol addiction. (Kahan.M.1996)

The CAGE (Cut Annoyed Guilty Eye Opener) questionnaire which includes four questions is widely used to screen alcoholic patients quickly.

In this two "yes" responses indicate that the respondent must be investigated further. The questionnaire includes the following questions.

1) Have you ever felt you needed to cut down on your drinking?
2) Have people annoyed you by criticizing your drinking?
3) Have you ever felt guilty about drinking?
4) Have you ever felt you needed a drink first thing in the morning (Eye opener) to steady your nerves or to get rid of a hangover? (J.A Ewing 1984).

The CAGE questionnaire is a highly effective tool to detect alcohol related problems; however it has some limitations in people with less severe alcohol problems, white women and college students. (Dhalla,S. *et.al,* 2007)

Another test such as Alcohol Dependence Data Questionnaire is a more sensitive diagnostic test than CAGE questionnaire. It helps to distinguish

alcohol dependence from heavy alcohol use. (Raistrick, D. *et al,* 1983). The Michigan Alcohol Screening Test (MAST) is a widely used most common screening tool for alcoholism by courts to proper sentencing for people committed alcohol related offenses and driving under alcohol influence. The Alcohol Use Disorders Identification Test (AUDIT) is an international screening questionnaire developed by the World Health Organization. Just like CAGE questionnaire it includes a set of questions. The high score needs further investigation. The Paddington Alcohol Test (PAT) is used by those attending Accident and Emergency departments. Another important internationally accepted test is SADD (Short Alcohol Dependence Data) questionnaire which consists 15 questions and is developed by Raistrick (Raistrick D *et al*, 1983).

Genetic predisposition testing

Psychiatric geneticists John I. Nurnberger, Jr., and Laura Jean Bierut suggest that alcoholism does not have a single cause—including genetic—but that genes do play an important role "by affecting processes in the body and brain that interact with one another and with an individual's life experiences to produce protection or susceptibility". They also report that fewer than a dozen alcoholism-related genes have been identified, but that more likely await discovery. (Nurnberger, *et al.* 2007).

Human dopamine receptor genes have a detectable variation referred to as the DRD2 Taqi polymorphism. Those who possess the A1 allele (variation) of this polymorphism have a small but significant tendency towards addiction to opiates and endorphin-releasing drugs like alcohol. Although this allele is

slightly more common in alcoholics and opiate addicts, it is not by itself an adequate predictor of alcoholism, and some researchers argue that evidence for DRD2 is contradictory.

Urine and blood tests

There are reliable tests for the actual use of alcohol, one common test being that of blood alcohol content (BAC). These tests do not differentiate alcoholics from non-alcoholics; however, long-term heavy drinking does have a few recognizable effects on the body, including: (Das, S.K *et al.*, 2008).

- Macrocytosis (enlarged MCV) Mean corpuscular volume.
- Elevated GGT-Gamma Glutamyl Transpeptidase
- Moderate elevation of AST –Aspartate Transaminase -and ALT-Alamine transaminase- and an AST: ALT ratio of 2:1
- High carbohydrate deficient transferrin (CDT)

However, none of these blood tests for biological markers is as sensitive as screening questionnaires.

DSM diagnosis

The DSM-IV diagnosis of alcohol dependence represents one approach to the definition of alcoholism. In part this is to assist in the development of research protocols in which findings can be compared to one another. According to the DSM-IV, an alcohol dependence diagnosis is:

... maladaptive alcohol use with clinically significant impairment as manifested by at least three of the following within any one-year period:

tolerance; withdrawal; taken in greater amounts or over longer time course than intended; desire or unsuccessful attempts to cut down or control use; great deal of time spent obtaining, using, or recovering from use; social, occupational, or recreational activities given up or reduced; continued use despite knowledge of physical or psychological sequelae

Dual addictions

Alcohol itself is sedative hypnotics and is cross tolerant with other sedative hypnotics such as barbiturates and benzodiazepines. Hence some alcoholics may require treatment for some other psychotropic drugs also. These drugs increase craving for alcohol and the volume of consumption to problem drinkers. It requires careful reduction in dosage to avoid withdrawal syndrome and other health hazards. (Anthony Radcliffe, Peter Rush *et al*, 1985)

Treatment of Alcohol Addiction

The disease of addiction affects the whole person physically, mentally, psychologically, socially and spiritually. Hence therapy for the addict should be in his totality.

Treatment for Alcohol Addiction: Well known Methodologies

Now days there are many widely used alcohol addiction treatment approaches. They include outpatient alcohol treatment and counseling, detoxification, residential inpatient alcohol addiction rehabilitation methods and family and marital counseling. (Jacob Marshak, 2009) Depending on the severity of addiction the patient has given inpatient or outpatient alcohol addiction treatment.

Various methods in different fields have been implemented by various professionals. These are medical management, psychosocial management and other techniques.

Medical Management

Medical management is necessary to handle alcohol addiction problems. Detoxification and administration of medicines comes under the medical management.

Detoxification

Alcohol detoxification is the procedure of allowing the body to get rid of alcohol and at the same time controlling the withdrawal symptoms in a favorable environment.

Alcohol detoxification is the first step in an alcoholic rehabilitation programme and is usually done under the supervision of a physician.

Therapeutic Drugs

Alcoholics take doctor prescribed drugs such as disulfiram (antabuse) or naltrexone (ReViaT) to prevent returning to drinking alcoholic beverages after he or she has relapsed. In this method physician prescribes drugs to treat alcohol addiction.

Ant abuse is a drug given to people who are alcohol dependent, that can elicits negative outcomes such as vomiting, flushing nausea or dizziness if alcohol is consumed.

Ant abuse is effective because it is a realistic deterrent. Naltrexon (ReViaT) on the other hand targets brain's reward circuits and is effective because it reduces the strong desire the alcoholic has for alcohol.

Psychosocial management

Psychosocial management consists of different methods of psychological procedures. They are as follows.

1. Individual counseling
2. Group therapy
3. Family therapy
4. Behavioral therapy

Individual counseling

Individual counseling is the technique which involves insight, persuasion, suggestion, reassurance and instruction, so that the patient can see themselves and their problems more realistically and can develop coping strategies. Individual counseling has to be given in a long term basis.

Group therapy

Group therapy is the techniques of treating patients in groups. This technique emphasizes the fact that the patient's problems are not unique.

Family therapy

Family therapy can be defined as the treatment of more than one member of a family simultaneously in a session. The problem experienced by one member of a family may lead to disturbances in the other family members and may affect interpersonal relationships and functioning.

Behavioral treatment for alcohol addiction

Behavioral alcohol addiction treatments usually include cognitive behavioral therapy, motivation enhancement therapy and Alcoholics Anonymous.

In a study administered by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) each of these three methodologies helped to decrease drinking alcohol in clients the year after treatment.

Alcoholics Anonymous

Alcoholics Anonymous is a mutual support programme for recovering alcoholics that is based on 12 steps of recovery that are necessary in order to stay sober. Through attending meeting on a regular basis assistance and support are provided.

Even though Alcoholics Anonymous is an effective alcohol addiction therapeutic tactic it is found that Alcoholics Anonymous works best with other types of therapy such as psychotherapy and medical care.

Motivation Enhancement Therapy

This method uses motivational strategies to produce the clients own change mechanisms. The following are some of the fundamental aspects of Motivational Enhancement Therapy (MET).

- Providing the client with a range of nontraditional change choices
- Therapist empathy
- Helping the client achieve self efficacy or a sense of optimism
- Providing feedback on the subject of the individual risk or damage interrelated with the abuse

- ❖ Receiving commonsense advice to make healthy life modifications
- ❖ Emphasis on taking personal responsibility for beneficial change

Cognitive Behavioral Therapy

There are different varieties of cognitive behavior therapy. The commonalties of these are as follows.

- CBT is established on stoic philosophy
- In CBT – a solid therapeutic relationship is a requisite but not the essential focal point for effective therapy

In the treatment for alcohol and drug dependence the main goal of cognitive behavioral therapy is to help the person to recognize situations in which they are most likely to drink or use drugs and avoid these situations and cope with other problems and behaviors which may lead to their substance abuse.

Approaches to Cognitive Behavior Therapy

According to the National Association of Cognitive Behavior Therapists there are different approaches to CBT which includes Rational Emotive Behavior Therapy, Rational Behavior Therapy, Rational Living Therapy, Cognitive Therapy and Dialectic Behavior Therapy.

Components of CBT

CBT has two main components. They are Functional Analysis and Skill Training.

Functional Analysis

Here the therapist and the patient working together to identify the thoughts, feelings, and situations of the patient before and after they drank or used drug. This helps the patient to identify the risk factors that may lead to a relapse. Functional analysis can give an insight to the person why they drink and identify situations in which the person faces coping difficulties.

Skill Training

The goal of CBT is to help the person to learn or relearn better coping skills instead of using alcohol as the main means of copying with problems. The therapist helps the person to unlearn old habits and learn to develop healthier skills and habits.

Assertiveness Training

Assertiveness training helps people to overcome anxieties and inhibition. It aids in the development of greater interpersonal skills and more effective and spontaneous social behavior.

Assertiveness is an essential trait to be developed by the recovering patient and this play a crucial role in both recovery and alcohol relapse prevention.

Relaxation therapy

Relaxation therapy is a form of behavioral therapy in which the patient is trained to relax by demonstration of opposing feelings of tension and relaxation. It helps them to avoid insomnia and other psycho physiological disorders.

Biofeedback

It focuses on the direct modification of physiological responses as opposed to cognitive or motor responses. In the treatment of chemical dependent person's biofeedback used to teach them to bring about a relaxation response.

Electro sleep

In this method low voltage electrical current is passed through the head of the patient and it produces a state of relaxation accompanied by a sense of wellbeing or euphoria.

Other technique

Acupuncture

Acupuncture method is in varied types. Some of them consists placement of needles without electrical current and some other approaches consist placement of needles in the ear or earlobes followed by the passage of low voltage current across the head. It can alleviate agitation and pain of withdrawal and produce rapid sedative or euphoric effects on the client.

All the above mentioned approaches to the treatment of chemical dependency are taken from the Life Extension Magazine of Jacob Marshak (2009) and from Alcoholism and Drug dependency, Professional Master Guide (1989) published by TTK Hospital.

No cure for Alcohol Addiction

Since the medical community has not developed a cure for alcohol addiction, from a different perspective, if alcoholism is treated early alcoholic recovery is entirely possible.

Natural Remedy for Alcoholism, Indian Naturopathy

Hemalatha Murthy (2011) explains the natural remedy for alcoholism.

Addiction to alcohol is known as alcoholism and natural remedy for alcoholism deals with bringing back body's nutritional integrity to prevent craving for alcohol. Due to physical or psychological reasons a person who is addicted to alcohol is unable to stop it quickly.

After the preliminary fast with juices a favorable diet with vital nutrients is essential. Such a diet includes whole grains, cereals, nuts, seeds and sprouts, fresh juices and vegetables. The best substitute drink for alcohol is a glass of fruit juice sweetened with honey. All refined foods like sugar, polished rice, macaroni products and white flour and meat should be avoided. The patient should avoid heavy meals instead can take several small meals. The patient should also avoid strong condiments such as pepper, mustard and chili. Since smoke will increase the desire for alcohol that also should be avoided. Apples are considered valuable in the treatment of alcoholism since it removes intoxication and reduces the desire for intoxicating liquors. In addition to proper nutrition, plenty of rest and outdoor exercises are essential. Exercise improves the healthy condition of the appetite centre which controls the craving for alcohol. *Yogasana* such as *Padmasana, Vajrasana*, *Vakrasana*,

Paschimottanasana, Yogamudra, Bhujangasana, Halasana and *Salabhasana* will also be beneficial.

Music therapy

Music is an important in mood changing and reliving stress, which works on many levels at a time. Hence from the ancient times music has been used as the therapeutic agent music produces the effect of yoga through the generation of sonorous sound, which acts upon human organism to awaken and develop the proper function of various organ systems so it can lead to self realization. Music helps in the treatment of the diseases in the following ways.

- Music act as a sedative and can replace the use of tranquilizers or can reduce the dosage of tranquilizers.
- Music increases the metabolic activities within the human body. It affects the central nervous system and circulatory system of the listener of the music. Many researchers suggest that the rhythm of the music or the beats that has the calming effect on the nervous system of a person without having conscious awareness about it.

Diet therapy

Diet is the most important part and a nutritious diet helps keeping new disease from affecting the body. Ayurveda suggests that a balance diet is not sufficient for good health but it proposes that specific bodily conditions require specific diets. According to Ayurvedic philosophy diet as an alternative therapy and treats the body as a combination of three different factors called *vata*, *pitta* and *kapha*, These three factors represent air, earth, fire, water and space (akash)

respectively. In a healthy body all these five elements are perfectly in a balanced state, and which can be achieved through proper diet. When any one of these elements is disturbed the body becomes prone to disease which can be cured by proper diet.

Diet therapy is a process of treating diseases of body by eating a diet which includes necessary curative and preventive ingredients. Even medical practitioners claim that a healthy diet plan can cure diseases and also help to prevent disease.

Diet therapy is a noteworthy alternative therapy by following a well structured diet plan for healthy living or be it with a plan of diet for different diseases. (Hemalatha Murthy, 2011).

Alcohol Relapse and Craving

There is clear cut evidence that approximately 90 percent of alcoholics experience at least one relapse within 4 year period after their treatment. (Polich, J.M, *et al* 1981). Relapse is common among chemically dependent people and is considered as a part of chemical dependency, impaired control has been considered as a determinant for relapse but investigators defined it differently. Keller (1972) suggested that impaired control can be defined in two ways i.e. the unpredictability of an alcoholic's choice to get away from first drink and the inability to stop drinking if started. Other investigators (Ludwig, A.M *et al* 1974, 1978, Hodgson, R.J 1980) defined the use of 'impaired control' as a person's inability to stop drinking once started. According to them one drink does not lead inevitably to excessive drinking. Research has shown

that the ability to stop drinking after the first drink depend upon the severity of chemical dependency. (Hodgson, R.J, & Stockwell, T.R 1979, 1980).

Craving for Alcohol

Ludwig and associates stress the relationship between the behavior of drinking and environmental stimuli that prompt the behavior and de emphasize physiological urges. They suggested that alcoholics experience classical conditioning by pairing of external stimuli (e.g. familiar bar) and internal stimuli (e.g. negative mood state) to the reinforcing effects of alcohol which is pleasurable (Ludwig *et al*, 1974).

This theory suggests that just like hunger, craving for alcohol is an appetitive urge, which varies in intensity and is characterized by withdrawal symptoms. The withdrawal symptoms are elicited by the memory of the euphoric effects of alcohol and of the discomfort of withdrawal, which is evoked by internal and external stimuli. Physiological responses to alcohol use are explained. Research has shown that without consumption, only exposure to alcohol can increase an alcoholic's salivary response (Pomerlean, O.F *et al*, 1983). In response to alcohol cues skin conductance levels and self reported desire for alcohol were correlated and the relationship was very strong for those most chronically dependent. (Kaplan, R.F *et al*, 1983). After the consumption of a placebo beer, alcoholics show significantly greater rate of insulin and glucose responses than non alcoholics (Dolinsky, Z.S *et al*, 1987).

Several relapse prevention techniques incorporate the concept of self efficacy which indicates that individual's expectations about his/her ability to

cope with a situation will influence the outcome (Bandura, A. 1977). Marlatt and Colleagues (1978, 1980) found that the transition from the initial drink after a certain period of abstinence to excessive drinking is affected by an individual's perception of and reaction to the first drink.

High Risk Situations

When analyze the cognitive behavioral aspect of relapse these investigations found that relapse is affected by the interaction of conditioned high risk environmental situations, skills to cope with the high risk situations, level of perceived personal control and the anticipated positive effects of alcohol.

An analysis of 48 episodes made it clear that most relapses were associated with three major high risk situations which are frustration and anger, social pressure, and interpersonal temptation. (Marlatt, G.A 1978). Cooney and associates supported this theory and found that among alcoholics exposure to alcohol cues was followed by loss of confidence in the ability to resist drinking (Cooney & associates, 1987).

Skills Training Intervention

The effectiveness of skills training intervention to help alcoholics to cope with relapse risk was investigated by Chaney and associates. To handle specific high risk situations the alcoholics learned problem solving skills and rehearsed alternative behaviors. The investigations suggested that to prevent relapse, skills training may be an effective component of a multimodal behavioral approach (Chaney & associates 1978).

A relapse prevention model for alcoholics by Annis, H.M *et al* (1986) stresses a strategy that helps each individual develop a profile of previous drinking behavior and present expectations about high risk situations. The therapy encourages implementation of coping strategies and behavioral change by allotting the patient in performance based homework assignments in relation to high risk situations

Preliminary outcome data indicated a decrease in the number of drinks consumed per day as well as in drinking days per week. Over the three months follow up period 47 percent of the clients reported total abstinence from alcohol and 29 percent reported total abstinence over the entire 6 months follow up period (Annis, H.M *et al,* 1988).

Preliminary neurochemical studies showed that if the level of brain serotonin is decreased that may cause appetite for alcohol. Alcohol preferring rats have decreased levels of serotonin in different regions of the brain (Murphy, J.M *et al,* 1982). More than that drugs that can increase the brain serotonin activity reduce alcohol consumption in rodents (Amit, Z. *et al*, 1984, Naranjo, C.A. *et al,* 1986).

Relapse is a common process in the alcohol and drug recovery process. Approximately 90% of recovering addicts have at least one relapse before they achieve lasting sobriety. Relapse is a slow process, a slip doesn’t begin when the person picks up a drink or a drug but it begins long before the person actually use.

The steps to a relapse are changes in attitude, feelings and behavior that gradually lead to the final step of drinking. In 1982 the researcher Terens.T Gorski and Merline Miller identified eleven warning signs or steps that typically lead to a relapse. They are:

1. **Change in Attitude:**

The person may return to a state of thinking what some call stinking thinking. The person feel something is going wrong but can't recognize what exactly it.

2. **Elevated stress:**

After a period of residential treatment the person is returning to the real world and it can present many stressful situations. The person must be careful in handling mood swings and extreme positive or negative feelings.

3. **Reactivation of denial**

Even though the condition of the person is not ok he may try to convince that everything is normal. The person may be scared or worried but never share those feelings with anybody. This denial is the same as to the denial of alcohol addiction or abuse.

4. **Recurrence of post acute withdrawal symptoms**

After the person quit drinking he may continue to experience anxiety, depression, sleeplessness and memory loss. During times of stress these symptoms may return and the person may be tempted to use alcohol or drug to compensate this stress.

5. Behavior change

During early sobriety the person may change the daily routine that helped to replace the person's compulsive behaviors with healthy alternatives. The person may start poor judgment and that cause problems due to impulsive behavior without thinking properly.

6. Social breakdown

The person may start feeling uncomfortable with others and making excuses for not to socialize. The person avoids sober friends or withdraws from family members. He likes loneliness and isolates himself.

7. Loss of structure

The person completely abandons the daily routine and start sleeping late or neglecting personal hygiene or skipping meals. The person begin to focus small part of life having tunnel vision do not see other areas of life.

8. Loss of judgment

The person has trouble in making decisions or make unhealthy decisions. He feels difficulty in controlling his feelings and emotions. He is not being able to relax, always feel overwhelmed without apparent reason. The person may get irritated and easily get angry.

9. Loss of control

The person may begin to make irrational and stick on to those choices. He thinks he can return to social drinking. The person loses confidence in his ability to control life.

10. Loss of options

The person starts to limit his options and do not think broadly.

11. Stop attendance at AA and follow-up meeting

He stops meeting with counselors and support groups. This leads to the feeling of loneliness, frustration, anger, resentment and tension. (Terense T. Gorski & Merline Miller 1982)

The person believes that there are only three ways in front of him i.e., insanity, suicide or self medication with alcohol or drugs. (Miller, W.R. *et al*, 2000)

Concluding the introduction

Though much advancement has taken place in the theory and therapy of alcoholic dependence problem, a clear solution to the problem is far away. The complexity of the body chemistry due to alcohol abuse and its further complex psychosocial implications lead the researcher to a lot of inconclusive stand points. For example the medical intervention of de-addiction including psychological methods is found to be partially effective in about 30% of the cases. That too works with only the highly motivated and cooperative clients. Moreover the adverse effects of detoxifying and aversive drugs are to be considered. There are ample indications that psychological intricacies are of much importance in the therapy of alcoholism and psychosocial approaches are more important than the medical interventions. Counseling and Psychotherapy is of utmost importance in de-addiction centers, is a well known fact.

AIM OF THE STUDY

The present study attempts to investigate the efficacy of psycho nutritional cure procedures (Yogic diet – raw food, *yogasana* meditation and various psychotherapies). This kind of an investigation is almost a rarity in the field of alcoholic dependence problem.

The principles and philosophy of psycho nutritional cure

The health and etiology based on nutrition was viewed by ancient systems of medicine all over the world. Nutrition do not consist food alone but it includes *panchabootha* elements. In the terminology of modern science, trihumour *(thridosha)* and tetrahumour *(chadurdosha)* theory can be explained thus. Out of 108 or more elements identified, only 24 or 26 elements constitute the human body as protoplasm. According to Ayruveda, we experience health or constant happiness *(nirantharananda)* only when the proportion of the protoplasm is in proper level or proportion. In an article entitled 'correct nutrients cure disease' explain the philosophy of natural cure (Baby J, 2004).

We experience ill health if the constituent elements of the body are in disequilibrium. This disequilibrium occurs in many ways by entering nonfood substances in to the body through air, food, water, radiation etc. The unassimilated nonfood substances which are harmful to our body are called toxins or *dusht*. Our body will always try to eliminate these toxins through our excretory organs. This process of eliminations is called disease symptoms. So in psycho nutritional cure the disease is not considered as something harmful

but it is viewed as the body's attempt to save the body from harmful toxic substances.

There are numerous disease symptoms as a result of toxicity such as vomiting, diarrhea, ulcers, fevers, bleeding, pus, headache, anxiety, temper and even psychosis, the reason for all is toxemia. Sometimes this toxin can be deposited in the form of tumor. The toxins with chemical characteristics are more harmful. All unassimilated things are not considered as toxins such as the roughages in fruits and vegetables are not assimilated by the body which are not harmful instead they are useful for the peristalsis in digestion.

Nutritional deficiency also is a cause of many diseases and some deficiencies can be overcome by the body itself through synthesis.

In order to maintain life, the living bodies evolved or created out of the five physical elements *(Panchaboothas)* are in constant interaction with its constituent elements. As a result of modern artificial living the body may keep away from *panchabhoothas* and that will cause ill health. We need oxygen through our breath, unboiled water and unboiled food. An unpolluted fresh air is needed for our living body. The skin need constant interaction with air, water, earth etc and the living organism is a part of the universe. It takes nutrition from the basic elements of *panchabhoothas* from the universe. This aspect is mostly ignored in modern medical practice. Germs are not the actual cause of disease. The germs cannot attack a healthy body. When *prana* or bioenergy get depleted the germs become active and disease symptoms will appear. Hence it is clear that germs are not the primary cause of disease; they

are only the after effect when bioenergy is depleted. We cannot completely germicide our body because many germs are essential to our body such as those involved in digestive process. Man is vegetarian, the clear cut evidences for that are present in modern sciences like Anatomy, Physiology, Morphology, Biochemistry, Endocrinology etc. precisely a frugivorous aminal i.e. eating ripe and fallen fruits and nuts and a few vegetables – which are edible for human beings. A famous biologist Harriward Carrigton (1964) provides hundreds of scientific arguments and evidences to prove these facts. The major evidences are listed below.

The length of the digestive canal of a normal medium size cow is about 32 feet (from mouth to anus). But a tiger longer than a cow has a digestive canal of 12 feet length only. In the case of human beings, if we are carnivorous our digestive canal should have 12 feet or less. But the length of the human digestive canal is between 24 and 30 feet. The carnivorous animals eat flesh and bones along with skin, hairs and blood of other animals. Human digestive enzymes are similar to that of the vegetarian animals.

Human blood contains 80 percent alkaline and 20 percent acidic contents which is similar to that of vegetarian animals. The vegetarian animals can move their lower jaw towards left and right. e.g.: cow, horse, elephant, hippopotamus, giraffe, camel many varieties of vegetarian pigs, monkeys and man but the carnivorous animals just bite and swallow the flesh, bone skin etc without chewing. They have digestive enzymes, which is very strong and mostly of acidic contents.

Another difference is vegetarian animals drink water by sipping, while the carnivorous animals drink by licking. Vegetarian animals are active during day time and they sleep during night while the carnivorous animals are active during night and often sleep during day time. The sebaceous glands or sweat glands are present only in vegetarian animals. The vegetarian animals open their eyes at the time of their birth while the carnivorous animals open their eyes after several days. The retinal chemistry of carnivorous animals and vegetarian animals are different.

Summary of principles and assumptions of psycho nutritional cure

The following principles and assumptions of psycho nutritional cure are derived from orthopathy books and from experiential evidences and empirical proof from psycho nutritional cure camps held for the pilot study of this research. The principles depicted here are the content of a Health Awareness Inventory. (Ashraf.C 2008, Baby.J 2004 & Veeramanikandan, 2009).

(a) Fundamental principles of health

(1) The body cells (protoplasm) are made out of the elements in the universe. The proportion of the combination of these elements is the basis of health.

(2) Health is that happiness experienced when the proportion of the body elements is in exact proportion.

(3) Genetic defects can be a cause for the disequilibrium of body elements.

(4) Life (health) sustains only through receiving nutrients constantly from external materials or *panchabhoothas* (air, earth, water, sunlight and ether).

(5) The vital energy will be most powerful when the body cells are pure.

(6) Some people even if they eat wrong food remain healthy due to their inborn vital power.

(7) A person lives or dies depending on her / his vital power.

(b) Fundamental causes of disease

(1) Often diseases happen when harmful no nutrient materials enter the body.

(2) A major cause of disease is the disequilibrium of the body constituents.

(3) Hostility, hatred, pride and selfishness all these would cause disease.

(4) Germs are not a primary cause of disease but an effect of depletion of bioenergy.

(5) Germs cannot attack a pure body.

(6) Disease symptoms indicate the presence of vital power in the body. A body that cannot bring symptoms has less vital energy and is in danger.

(7) All materials that are not assimilated by the body are not harmful, that having chemical characteristics are more harmful.

(8) Disease is not the cause of death, loss of bioenergy is the cause of death and disease symptoms are the warning signals of depletion of bioenergy.

(c) What are disease symptoms?

(1) Disease symptoms are the excretion or elimination of harmful toxic substances through skin and the nine outlets of excretory organs, or storing them in the form of a tumor.

(2) All disease symptoms are the wise attempts of the body to save the body.

(3) Triggering a disease symptom and its removal are the activities of the body itself.

(4) A healthy body manifests symptoms. When the cause is removed the symptom will automatically disappear.

(5) Fever, diarrhea, skin disease, ulcer, etc. are all purification processes of the body.

(6) Fear is a prominent symptom. A toxic body will be affected by fear.

(d) The precise nature of drugs

(1) Though the drugs suppress symptoms temporarily, later the symptoms will reappear with more severity.

(2) Nonnutritive drugs work as a stimulant in the body not an assimilate.

(3) The life span of those who take more strong drugs will get reduced.

(4) The belief that drugs cure disease is a very prominent superstition in the world. Drugs only suppress symptoms. Suppression is not cure.

(5) Nutritional correction alone is enough for a cure and no need for any drug application (except on emergencies).

(6) Application of drugs can be acceptable only on certain emergencies like snake bite and accident injuries.

(7) Most diseases occur due to the application of drugs.

(8) Harmful drugs are there in systems like Ayurveda, Siddha, Unani and Homeo systems of Medicine other than Allopathy.

(9) Only when the nutritional correction fails to cure a disease, then only drugs or surgery should be done.

(e) The exact nature of cure

(1) Cure takes place automatically when the cause of disease is removed.

(2) Physical conditions like clean air, water, food and proper rest are sufficient for a cure.

(3) Bodily purity is the main requirement for the equilibrium of the mind (health).

(4) Cure is an automatic process of the body and nutrition is the most influencing factor in this process.

(f) Fundamental principles of food

(1) Edible fruits, nuts, vegetables, sprouted grains cereals and vegetables in the uncooked form are the most suitable food for human digestive system.

(2) Second to raw food, the next suitable food is spice less and salt less cooked food.

(3) The preserved and processes food sold in tins, packets and bottles are more harmful as they contain chemical preservatives.

(4) Food alone is not our nutrients, air, water, atmospheric temperature, pressure, gravitational force all such physical conditions are also nutrients.

(5) The calorie theory on nutrition is incomplete and inadequate.

(6) All the nutritive aspects about raw food are not known to science.

(7) White sugar, processed grains (mida) hydrogenated oils and such incomplete items and chemical salt are highly harmful.

(8) Animal food may cause fatal diseases in most people.

(9) The personal preferred natural food is the most suitable food.

(10) Our natural taste preference is destroyed by spicy food, which can be brought back by natural food alone.

The above principles are derived from classic books on Orthopathy the scientific version of Nature cure developed by Allopathy doctors in the West and empirical investigation done in this field.

The present study is based on the theory of cure envisaged in the philosophy of cure, which cannot be attributed to any particular system of medicine, other than Orthopathy and the *Panchabhootha* based nature cure propagated by Mahatma Gandhi in India.

REVIEW OF LITERATURE

REVIEW OF RELATED STUDIES

Well controlled studies on therapy outcomes of the alcoholic dependency problems are reviewed here. Most of the studies are reported from abroad and very few studies are available from India.

Duran *et al*, (2005) studied about the obstacles for Rural American Indians to take alcohol, drug or mental health treatment. The main objectives of the study was to find out factors related with 4 clusters of obstacles namely self reliance, privacy issue, quality of care and communication and trust to mental health and substance abuse treatment in 3 treatment sectors for residents of 3 reservations in the United States. The number of participants was 3,084. They opened whether they get treatment for emotional, drug or alcohol problems in the past year, if so, whether they had faced problems in obtaining care from Indian health services, tribal services and other private or public systems. They identified obstacles in this study are negative social support, instrumental social support, utility of counselors, utility of family doctors, treatment sector, treatment type, diagnosis of an anxiety disorder and tribe.

Davis. S.J. *et.al*, (2006) conducted a survey to know the attitude towards spirituality and the core principles of Alcoholics Anonymous. The sample consists of 151 students who were enrolled in substance abuse counselor training classes. Among them a survey was conducted on their attitude about spirituality, substance abuse treatment and beliefs about Alcoholic Anonymous principles (AA). The result of the survey shows a positive correlation between

the subject's spirituality and their attitudes toward spirituality in treatment. Most of the students agreed that spirituality should be included in treatment but they did not tend to subscribe to core principles of Alcoholics Anonymous.

Another study was conducted by Chen, Gila (2006) about natural recovery from Drug and Alcohol addiction among Israeli prisoners. The purpose of the study was to examine the differences in the sense of coherence, anxiety, depression, hostility behavior and meaning in life among Israeli prisoners recovery from drug and alcohol addiction over various time periods about 6-24 months and without therapeutic intervention i.e., natural recovery. For this ninety eight abstinent prisoners were divided into two groups. In group one participant had six months abstinence and in group two participants had abstinence between 6 and 24 months. In this study group two participants showed a higher sense of coherence and meaning in life, lower level of anxiety and depression and better behavior. The findings reveal that among addicted prisoners natural recovery is possible and personal and emotional changes are associated with the duration of abstinence.

Panuzio, J. *et al.* (2006) examined relationship of aggression reporting concordance among 303 men with alcoholism disorders and their female partners enrolled in couples-based alcoholism treatment. The finding showed agreement for physical and psychological aggression and were generally consistent with or higher than concordance rate reported among other populations. Men's antisocial personality is a predictor of higher concordance in male and female aggression. In some analyses higher alcohol problem

severity, poorer adjustment in relationship and higher psychopathic personality features were associated with better concordance. Here women reported experiencing more physical aggression than men reported experiencing. They reveal the importance of taking aggression reports from both partners and the need for research investigating methods for better concordance.

There is a positive correlation between alcohol use and partner violence, which has an extensive empirical and theoretical support. (Stuart, G.L. 2005). Recent innovations in this area showed a strong temporal link between alcohol use and intimate partner violence. The majority of men who participating in batters intervention programs have alcohol problems and these men are at very high risk for violence and crime. Research has shown after obtaining alcohol treatment there is a decrease in partner violence among alcoholics. This study examined the rate of partner violence before and after behavioral couple's therapy (BCT) for 303 married or cohabitating male alcoholic patients and used demographically matched nonalcoholics as comparison sample. Result of the study indicates, in the year before BCT 60% of alcoholic patients had been violent toward their female partner 5 times than the comparison sample rate of 12%. In the first and second year after BCT violence decreased drastically from the year before BCT and clinically significant reduction in violence occurred on patients whose alcoholism was remitted after BCT. Structural equation modeling revealed that greater treatment involvement by attending BCT sessions and using BCT targeted behaviors was related to lower violence after

BCT and this association lead reduced problem drinking and enhanced relationship functioning.

McCrady, B.S. *et al,* (2004) reported the importance of Alcoholics Anonymous and Relapse prevention as maintenance strategies after conjoint behavioral alcohol treatment for 18 months outcomes. Ninety men with alcohol problems and their female partners were assigned randomly to 1 of 3 outpatient conjoint treatments: alcohol behavioral couple therapy, (ABCT), ABCT with relapse prevention techniques (RP/ABCT) or ABCT with interventions encouraging Alcoholics Anonymous (AA) involvement (AA/ABCT). After treatment, couples were followed for 18 months. Among the 3 treatments drinkers who provided follow-up data maintained abstinence for almost 80% of days during follow-up with no differences in alcohol consumption or marital happiness outcomes between groups. AA/ABCT participants attended AA meetings more regularly than ABCT or RP/ABCT participants, and their drinking outcomes were more strongly related to concurrent AA attendance. For the total sample AA attendance was positively related to abstinence during follow-up in both concurrent and time lagged analyses. In the RP/ABCT treatment participation at post treatment booster sessions was related to post treatment abstinence. Among treatment conditions, marital happiness was related positively to abstinence in concurrent but not in time lagged analyses.

Kahler, C.W. *et al,* (2004) studied the effect of motivational enhancement for 12 step involvement among patients undergoing alcohol detoxification. For these 48 patients who were undergoing inpatient

detoxification for alcohol dependence were selected and provided either brief advice (BA) to attend Alcoholics Anonymous as a motivational enhancement for 12 step involvement (ME-12) intervention that pointed increasing involvement in 12 step self-help groups. Attendance at 12 step groups didn't differ significantly by treatment condition over six months of follow-up nor did drinking results. There was a significant interaction between twelve step experience and treatment condition showing that ME-12 was associated with better alcohol outcomes at the low ends of twelve step experiences whereas BA was associated with better alcohol outcomes at the high ends twelve step experience. Study reveals that among patients undergoing alcohol detoxification, ME-12 may be beneficial only to those who have little experience with twelve step groups.

Lunux, J.M. *et al,* (2002) made a critical evaluation about the psychometric usefulness of Michigan Alcoholism Screening Test (MAST). 94 subjects were presented for a chemical dependence assessment at a community mental health and addiction treatment centre. The results show that the MAST is a psychometrically sound instrument very useful for screening for the presence of alcohol related problems in an outpatient group. Results also reveal that the MAST is not useful to overcome client defensiveness or denial. In this study implications for Counselors and suggestions for future research are discussed.

Vander Wade, H. *et al,* (2002) studied about women and Alcoholism: A bio-psychosocial perspective and treatment approaches. Here alcoholism in

women is viewed from a bio-psycho social perspective and it reveals a set of circumstances and challenges that women alcoholics face than with men. Biologically women do react differently to alcohol ingestion than do men. If men and women consume equal amount of alcohol, women reach higher blood alcohol levels and sustain more somatic and cognitive damage than men. Psycho socially women alcoholic face societal rebuke and chastisement to a greater magnitude than men do. Female alcoholics face treatment barriers such as the need for child care, cost of treatment, familial opposition and denial of alcoholism and inadequate diagnostic training of physicians. These problems must be overcome to create successful treatment approaches for the alcoholics. Obstacles and implications for treatment are discussed.

Majer, J.M. *et al.*, (2004) conducted a study on optimism, abstinence, self efficacy and self mastery: A comparative analysis of cognitive resources, they investigated levels of cognitive resources such as optimism, abstinence self efficacy and self mastery and its relationship among two samples of recovering substance abusers: Oxford house residents who attended twelve step groups and twelve step members who had never lived in an oxford house. The study revealed that participants level of optimism were significantly and positively related to both abstinence self efficacy and self mastery scores and abstinence self efficacy was significantly and positively related to the number of days abstinence of participants. Participants who abstained for more than 180 days reported significantly higher levels of abstinence self efficacy than participants who abstained less than 180 day's abstinence, oxford house

residents reported higher levels of abstinence self efficacy than twelve step members. The findings of the study suggest that cognitive resources facilitate substance abuser's recovery and the oxford house model might give greater levels of support in their abstinence process.

Another study by Moos, J. *et al.* (2004) about long term influence of duration and frequency of participation in Alcoholic Anonymous on individuals with alcohol use disorders is examined the influence of the duration and frequency of a baseline episode of participation in AA among 473 individuals with alcohol use disorders on 1 year and 8 year outcomes and the effect of additional participation and delayed participation on outcomes. Individuals who affiliated with AA relatively quacking and who participated longer had better 1 year and 8 year alcohol related outcomes compared with individual who did not participate and who continued longer had better alcohol related outcomes than individuals who discontinued participation. But individuals who delayed participation in AA had no better results than never participated. In conclusion, the frequency of participation was independently associated only with a higher period of abstinence.

Sales, Amos (2004) wrote a book about preventing substance abuse: A guide for school counselors. The focus of this book is to provide practical knowledge and skill needed and to get an action plan to implement prevention programmes in schools. This text is a resource for practitioners, students and faculty in school counseling. It facilitates opportunity to implement comprehensive prevention efforts for substance abuse and other behavioral

problems of youth across school curricular and extra curricular activities. To initiate the changes needed to implement a comprehensive prevention programme, school counselor is identified as the best professional. The specific steps needed are provided in this book.

Friedman, A.S. *et al*, (2004) conducted another study on the Role of Participant Motivation in the outcome of a prevention/early intervention programme for adolescent substance use problems and illegal behavior. The main objective of this study was to determine for a court adjudicated adolescent male sample (N=160) mandated to a residential camp setting, the intensity to which their expressed motivation for getting help with their alcoholism, illicit drug use and illegal behavioral acts was found to predict the outcome of an early intervention treatment programme. In this study those subjects who reported relatively more severe alcohol and drug problems at admission time expressed a greater degree of trouble by having such problems and it was more important to get help and counseling to these problems. Even though no significant relationship was found between the intensity of the illegal behavior problems and the degree of being troubled by having such problems or the degree which was considered more significant to get help for such problems. The reason for lack of concern regarding serious illegal behavior is the lack of opportunity that was available to them and the influence of the poor neighborhood in which they grew up. Those subjects who admitted it is more important to get help and counseling for their alcohol problem also reported relatively less alcohol problems at follow-up assessment. However some

participants who reported that it is more important to get help for alcohol problems also were found to report a greater degree of drug use at follow-up assessment. Hence we can see that some of the earlier alcohol consumption was exchanged for an increase in the degree of marijuana use. It is concluded that the ratings on motivation at the time of admission in these sample are to some degree meaningful but to a certain extend is misleading and that the implications of these motivation ratings are complicated.

Parks, Cheryl, A. *et al,* (2003) conducted a study among alcohol dependent Alaska natives on factors affecting entry in to substance abuse treatment and gender differences. He investigated the time between age of diagnosis and first treatment was similar for men and women. Most of the women were parents and reported frequent contact with health and mental health providers. Among men who were parent depression and type of professional consultation were more likely associated with lapsed time to treatment.

Riley, H. *et al*, (2003) conducted another study on Low Emotional Intelligence as a predictor of substance use problems. They conducted this study in adults and explored the relationship between low emotional intelligence and substance use problems. The sample size was 140 and participants completed the Self - Administered Alcoholism Screening Test (1,2), the Drug Abuse Screening Test (3), an Emotional Intelligence Scale (4), and a measure of psychosocial coping (5). The findings reveal that low emotional intelligence was a significant predictor of both alcohol and drug

related problems. In drug related problems poorer coping was reported but not in alcohol related problems. Coping was not found to be a significant factor between emotional intelligence and substance related problems. As a result of this study possible implications for intervention and treatment are discussed.

An article about Screening and Brief Intervention for alcohol problems among college students treated in a University Hospital emergency department is published by Helmkamp, J.C. *et al*, (2003). They evaluated screening protocol and provided a brief intervention for alcoholism. Among them 2, 372 drinkers to whom they approached 87% gave 'informed consent' of those 54% screened positively to alcohol problems i.e., Alcohol use Disorders Identification Test Score is less than or equal to 6. One half to two thirds of the students screened positively and drank 2 to 3 times a week, drank 7 or more drinks per drinking day or had experienced alcohol dependence symptoms during the past year. 96% of screened positive students accepted the importance of counseling during their ED visit. Three quarters of those questioned at three month follow-up reported counseling had been useful and they decreased their alcohol consumption. This study indicated the prevalence of alcohol problems, high rate of 'informed consent' and acceptance of need of counseling, and the improved outcomes suggest that ED is an appropriate venue for engaging students at high risk of alcoholism.

Cecero, J.J. *et al*, (2001) reported the influence of nonspecific factors in alcohol and unsafe sex treatment. The relationship between the nonspecific factors of therapeutic alliance and motivational outcome are demonstrated

across treatment modalities and mainly in the treatment of alcoholism. This study was designed to evaluate the association of these factors with treatment outcome in the preliminary sample of problem drinking men who have sex with men and indulge in unsafe sex. The hypothesis of the study was positive association between therapeutic alliance and percentage of session attendance and positive associations between three self reported motivational statements for alcohol, unsafe sex and session attendance. In this study 55 participants who enrolled in a clinical trial to reduce alcohol consumption and unsafe sex were included, and the results were contradictory to expectations. A positive association was not found between therapeutic alliance and outcome. When consider the motivational statements only the readiness to change alcohol consumption was correlated with outcome. The stability of self efficacy and risk assessment in alcohol and sexual behaviors suggest that motivational statements denote a more stable trait than able to generalize across behaviors. Findings of the study are consistent with the general notion that change in one's self efficacy or risk assessment for one behavior may result change in motivation for another behavior.

In an article by Baird, F.X. *et al,* (2001) about the Efficacy of Coerced Treatment for Offenders: An evaluate study of Two residential Forensic Drug and Alcohol Treatment programmes reviews the history of community based treatment for offenders with drug and alcohol addiction. This article describes the treatment regimen in two residential programmes for offenders including a description of the components of the residential treatment model used in these

two programmes. The findings of the study support the efficacy of coerced drug and alcohol residential treatment.

Another study by Malouff, J.M. *et al*, (2002) about the Expected Personality Characteristics of Alcohol dependent individuals, used the Big Five Personality Factors as a framework for examining the expected personality characteristics of individuals who are alcoholics. The results help to explain prior findings about the social disease of problem drinking with respect to making friends, dating, marriage and working. These findings have potential value in prevention and treatment of alcohol dependent problem.

Bobbe & Judith (2002) conducted a study entitled Treatment with Lesbian Alcoholics: Healing Shame and Internalized Homophobia for ongoing sobriety, stresses when working with lesbian alcoholics it is most important to be aware of shame and internalized homophobia as ongoing forces that can emerge and re-emerge within the client as she learns to lead qualitative sober life. Since stress plays an important role in relapse it is crucial to teach and train stress management techniques such as relaxation and meditation.

The transmission of Psychopathology from Parents to Offspring: Development and Treatment in Context was studies by Schwartz, S.J. *et al*, (2001). The study indicate that parental alcoholism is a prognostic factor of childhood behavior problems both directly through genetic and modeling effects and indirectly through parental distress and physical problems due to alcoholism. The hypothesis was the heightened rate of behavior problems in children of alcoholics could be due to the combination of negative interaction

with the alcoholic parent and the associated stress while living with an alcoholic.

In a book written by Trimble, J.E, *et al,* (2001) entitled Health Promotion and Substance Abuse Prevention among American Indian and Alaska Native Communities: Issues in cultural competence, indicates substance abuse continues to be one of the most damaging and chronic health problems faced by American Indian people. Substance abuse prevention and treatment Alaska Natives must be framed within the broader context of the widening health disparities between American Indians and Alaska Natives (Al/AN) communities and the general population. This book deals with successful treatment and prevention of health problems, including substance abuse, must be driven by community needs and blend complementary strategies from western medicine and traditional healing practices. This collection of works done by substance abuse experts and public health researchers explores, within a public health framework the multiple dimensions of Al/AN substance abuse treatment and prevention from an AI/AN community perspective.

Travers, R. *et al,* (1996) studied about Barriers to Accessibility for Lesbian and Gay Youth Needing Addiction Services. This study investigates the ways in which homophobia and heterosexism constitute barriers to treatment for lesbian and gay youth who are in need of addiction services. 17 gay and lesbian youth were interviewed and the results show barriers including marginalization, deflection and contradiction, outing, harassment, early discharge and misinformed staff. As a result of this study recommendations are

made for making addictions services more appropriate and accessible for lesbian and gay youth.

In an article by Tarter, R.E. *et al,* (1994) entitled Alcoholism: A Developmental Disorder, discussed alcoholism etiology from developmental behavior in a genetic perspective. In this article they examined the heightened risk for alcoholism in person with special temperament features, their interaction with the environment in the course of development are considered within epigenetic framework and have ramification for improving treatment and prevention of alcoholism.

Abstinence versus controlled use: A fresh perspective on a Stale Debate by Bruns, J.A. *et al,* (1995) examines whether an alcohol abuser can gradually learn to safely manage his intake. By building the gap between two perspectives that may empower therapists to explore in way of both abstinence and controlled use as a possible step to increase overall success of treatment in alcoholism?

The effect of random versus nonrandom assignment in a comparison of inpatient and Day Hospital Rehabilitation for male alcoholics was studied by Mckay, J.R. *et al,* (1995). This study examines differences in substance use and psychosocial outcomes under experimental and non experimental designs compared randomly assigned alcoholic patients to day hospital or impatient rehabilitation with patients who selected these treatment settings as their own. No better experienced outcomes were found in self-selecting patients compared with randomly assigned. The effect of the study is discussed.

Wadsworth, Rick *et al* (1995) explored issues surrounding sexual trauma and chemical dependency. This study aims to provide direction for relapse prevention with a relapse prone population and explores application by traditional milieu of substance abuse treatment for sexual trauma survivors. This study also helps to make recommendations for working with sexual trauma survivors who are also alcoholics.

Bristow-Braitman, Ann *et al,* (1995) studied the addiction recovery through 12 step programmes and cognitive behavioral psychology. This report provides an overview of treatment issues referred to as spiritual by those recovering addict through 12 step programmes, to the helping professionals. This report discusses spiritual constructs in terms of cognitive behavioral psychology.

Glover, N.M *et al,* (1995) examined the incidence of Incest histories among clients receiving substance abuse treatment. For this 77 volunteer participants enrolled in 8 substance abuse treatment facilities were surveyed to examine the prevalence and nature of incest contacts among the group. Results showed that approximately 49% of the participants had reported histories of incest and data's are presented under various parameters. Gender vice comparison was also done.

In a study by Mc.Donough, R.L, *et al,* (1994) describes about female alcoholism patterns, characteristics, and obstacles to treatment. They argue that the most effective treatment programme for female alcoholics requires consideration of gender related factors like relationship expectations and sexual

abuse. It outlines a holistic, comprehensive care model, intended to the unique needs and concerns of female alcoholics.

Atkinson, D.R. *et al,* (1994) have done a comparative study about Mexican American and European American Ratings of Four Alcoholism Treatment Programmes. 72 Mexican American and 196 Anglo Community College students were examined to know attitudes about alcohol use, addiction models, and the relative effectiveness of four types of alcoholism treatment programmes. In this study Mexican American students reported less alcohol consumption and rated all programmes as more effective than did Anglos. Among Mexican Americans acculturation was negatively correlated to programme ratings.

Le Christine *et al* (1995) conducted an information analyses about Alcoholics Anonymous and the counseling profession: Philosophies in conflict. It describes contributions of Alcoholics Anonymous (AA) to drug and alcohol treatment and discusses potential for AA's steps to encourage growth and examines its consistency with counseling philosophy. They propose and contrast 12 new steps based on counseling theory to promote constructive discussion. This analysis advocates more solid boundaries between AA and counseling.

Thomas, R.W. *et al,* (1993) have done a study entitled An Interpersonal Influence Processes in the "Home Treatment Method" of Alcoholism Intervention. This study examines the problem of alcohol abuse and role of communication in home treatment method associated with the intervention of

alcoholics. This study reviews nature of alcoholism and home treatment scenario and demonstrates how alcohol intervention involves communication issues and dynamic interpersonal influence and proposes research implications in areas such as avoidance, multiple goals, and alcoholic's responses to influence attempts.

Penny, Alexander, *et al*, (2012) conducted a study on Factors Associated with Recent Suicide Attempts in clients being presented for addiction treatment. They examined the clients who sought treatment at a de-addiction facility during the period between 2001 and 2008. 76 clients who reported being hospitalized for attempting suicide in the past year were compared to all other 5914 clients, on demographic, mental health, substance use, and problem gambling variables. The findings reveal that compared to all other clients, the clients who attempted suicide were less educated, and more likely to have major depressive disorder, a bipolar disorder, ADHD, a personality disorder or a gambling problem. Mental health issues are closely linked with suicide. Present study tries to find association between gambling and suicide. Since there is a strong relationship between mood disorders and gambling this findings support further research in to the possible connection between gambling and suicide.

'Alcohol treatment and cognitive Behavioral Therapy: Enhancing Effectiveness by Incorporating Spirituality and Religion' is a study by Hodge, David. R (2011). They found cognitive behavior therapy is an effective modality for the treatment of alcoholism. By incorporating spirituality in to

professional treatment this article helps practitioners to spiritually modified CBT, an approach which may promote outcomes in spiritually motivated clients by integrating client's spiritual beliefs and practices in treatment. This new modality may speed up recovery, enhance treatment compliance, prevent relapse and reduce treatment disparities by giving more culturally congruent service. In this article the process of constructing spiritually modified CBT self statements are described, and suggestions are given for working with client spiritually in an ethical manner. The article ends by stressing the importance of this approach in the light of growing spiritual diversity that characterizes contemporary society.

Hussong, & Andrea. M (2010), conducted a study with the title, Parent Alcoholism Impacts the Severity and Timing of children's Externalizing Symptoms. Using a multilevel modeling approach, they tested whether children aged 2 through 17 showed elevated mother-, father and child- reported externalizing symptoms (a) at the same time that parents showed alcohol related consequences (time varying effects), (b) if parents showed greater alcohol related consequences during the study period (proximal effects) and (c) if parents had a lifetime diagnosis of alcoholism that predated the study period (distal effects). To test this hypothesis they used an integrative data analyses to combine samples from two prospective studies. Distal effects of parent alcoholism on increased child externalizing symptoms were large and consistent, at the same time proximal and time varying effects of parent alcohol

symptoms were also present. The implications for preventing escalations in externalizing symptoms in this high risk group are also discussed.

In an article by Mackrill, Thomas (2008) on Exploring Psychotherapy Clients Independent Strategies for change while in therapy describes how clients change by continuing to use and revising the strategies for change that they bring with them when they first enter therapy. The data's presented in this article are from a qualitative diary study of psychotherapy. Here presented three cases describing three different client strategies for change. In this article they analyzed interplay between the client's strategies for change and the therapist's response. This study also describes how a strategy may be rejected or maintained and redirected and suggests that client's independent strategies for change may be a significant factor with respect to therapeutic processes and outcomes.

Litt, Mark. D. *et al,* (2007) conducted a study about changing Network Support for Drinking: Initial findings from the Network Support Project. The aim of the study was to determine whether a socially focused treatment can make change in the patient's social network from changing factors that reinforces drinking to one that reinforces sobriety. For this purpose 210 alcohol dependent men and women were recruited from the community were randomly assigned to 1 of 3 outpatient treatment facilities: Network Support (NS), Network Support plus Contingency Management (NS+CM) or Case Management (Case M, a Control Condition). Analysis of drinking rates for 186 participants at 15 months revealed a significant interaction effect of treatment

Verses Time, with both NS conditions yielding better outcomes than the case management condition. When analyzed social network variables at post treatment condition it is found that the NS conditions did not reduce social support for drinking relative to the Case Management condition but increased behavioral and attitudinal support for abstinence as well as Alcoholics Anonymous (AA) involvement. There is a significant correlation between NS variables and AA involvement variables with drinking outcomes. These findings indicate that a change in drinker's social network by a specifically designed treatment can contribute improved drinking outcomes.

Andreas, Jasmina *et al,* (2007) examined the longitudinal associations between father's heavy drinking patterns and children's psychosocial adjustment. For this 114 children of alcoholics were selected and examined, their psychosocial adjustment in the year before and at three follow-ups in 15 months after their alcoholic father's entry for alcoholic's treatment. The hypothesis was the children's adjustments problems will vary over time due to their father's heavy drinking in alcoholic fathers were formulated through cluster analysis. The findings revealed significant and meaningful associations between father's drinking pattern and children's adjustment problems over time. Children whose father abstained fully after their treatment showed lowest and few adjustment problems, while children whose fathers continued their heavy drinking after their treatment showed greatest and increasing adjustment problems over time.

Elliott, Karen, *et al,* (2006) was studying the Effects of Drugs and Alcohol on Behavior, Job Performance, and Workplace Safety. A study of records for a large U.S company revealed that those employees who had positive drug screens were fired, whereas workers who self disclosed their alcohol or drug problems remained employed. These two groups were offered substance abuse intervention and some workers who fired previously were rehired after they receive treatment. Accident results showed that when compared with self referred workers drug test positive employees had a significantly higher accident rate in all categories. Treatment data revealed that drug test positive workers had significantly higher accident rates before and after treatment. Post treatment results showed that drug test positive employees had decrease in accidents after treatment, while self referred group showed no change.

Crespi, Tony D. *et al,* (2006) had studied about Family Therapy and Children of Alcoholics Implications for continuing Education and Certification in substance abuse practice. Clinicians involved in family therapy are more concerned about the impact of parental alcoholism on individuals overall development and family functioning. With more than 20 million adults who raised within an alcoholic family and have widespread problems associated with parental alcoholism, and potentially large number of clients impacted by substance abuse are treated by clinicians, even though many clinician's lack specialty training. This article reviews the problems associated with parental

substance abuse and examines certification standard as a blueprint for further education and specialty training.

Relapse prevention for Alcohol and Drug problems: That was Zen, this is Tao was the title of a study by Witkiewitz, Katie, (2004). Relapse prevention based on the cognitive behavioral model of relapse has an adjunct to the treatment of many psychological problems such as substance abuse, depression, sexual offending, and schizophrenia. This article helps to make an overview of the efficacy and effectiveness of relapse prevention in the treatment of addictive disorders and it update the recent empirical support for the elements of the cognitive behavioral model of relapse and review the criticisms. It proposed a re conceptualized cognitive behavioral model of relapse that focuses on the dynamic interactions between multiple risk factors and situational determinants. The empirical support for this re conceptualization of relapse, relapse prevention and the limitations of the new model are also discussed.

An article by Adams, Christopher.M; *et al* (2008) about Incorporating Yoga in to College Counseling found in United States become increasingly popular and due to its popularity among college students it must be familiar with college counselors. This article gives an overview of yoga and research and its benefits for mental health promotion which is a general concern among college students. It addresses methods of incorporating yoga in counseling and provides a list of resources for college counselors.

Marquez, Genevive (2011) studied Yoga as a Burnout Preventive for Psychology Graduate Students. This project incorporates a selective literature review that examines psychological and physical benefits of emotional well being resulting from the practice of yoga. Such as, psychology graduate students usually experience unique stressors resulting from academic tasks and their exposure to emotional distress (Stratton, Kellaway & Rottinor 2007). Pervasive stress eventually lead to burnout, emotional exhaustion, and depersonalization and reduced personal accomplishment (Marslach, 1986). Burnout impinges on academic performance and quality of services provided to clients (Maslach, 1982). It is imperative that these population practice self care in a regular basis to prevent burn out state. Yoga facilitates mindfulness through its physical postures and breathing exercises. This research is applicable to develop a theory of self – care for graduate students in psychology since practicing yoga serves as a resource to prevent burnout in graduate trainees.

Machell, David F (1994) studied Combat Post Traumatic Stress Disorder, Alcoholism among the Police Officers. Result reveals clinical treatise describing and discussing about alcoholic police officers who are suffering from Combat Posttraumatic Stress Disorder (CPTSD). The study also discussed professional role immersion as a complication to the already complex treatment profile. The three layers of complication are CPTSD, alcoholism and role immersion need to be addressed in the addiction treatment efforts with this population.

A survey research was done by Ryan, Patrick (1993) in which he studied seven Roman Catholic dioceses of Florida to evaluate the level of awareness of alcoholism and need for treatment as indicated by prevalence of educational programmes, intervention and treatment. From this four dioceses reported some strategy in place, two others reported such a need and one reported consciousness of need was gradually emerging.

Wade, Jay.C (1994) in his article examines the role of unemployment, economic deprivation, racism, issues pertaining to gender roles and their contribution to substance abuse in African American men. This study specifically reviews the use of alcohol, opiates, crack, and cocaine and result shows that a bio psychosocial model offers the best framework in conceptualizing substance abuse treatment.

Long term outpatient treatment in alcoholics with previous suicidal behavior was studied by Ojehajen, Agneta *et.al,* (1993). They analyzed the importance of previous suicidal behavior in treatment of alcoholics. Among 72 patients, 21 had seriously threatened or attempted suicide earlier. Compared to other alcoholics those with previous history of suicidal behavior had similar attrition rate, were not more problematic in treatment and some rate of favorable outcome during third year after starting treatment.

Orenstein, Alan, *et al,* (1993) made a survey on Parental Substance Abuse Treatment and Adolescent Problems. They surveyed eleventh grade students (n=262) to compare two measures of parental drinking problems. Students who were distressed or discomforted due to their parents drinking did

not differ from other youth on outcomes which were measured. Students who reported their parents had been treated for alcohol or drug problems varied on several variables including substance abuse, delinquent behavior, and eating disorders.

Machell, David, F. (1992) developed a theoretical rationale in support of concept of fellowship, the healing cornerstone of Alcoholics Anonymous (AA). Literature from the areas of personality theory, group psychotherapy and alcoholism psychopathology and alcoholism psychological treatment are supporting this concept. It suggests a common premise and common ground of agreement for AA and the psychological community.

Phillips, Julia C & Heesacker, Martin (1992) examined the relationship between admission of a drinking problem and readiness to seek treatment for problem drinking among college students. They selected 422 students for the study. Result shows that student's (n=143) admission of alcoholism was significantly related to their readiness to change alcohol related behavior.

Frisch, Michael, B. *et al,* (1992) used The Quality of Life Inventory, a measure of life satisfaction for psychological assessment and treatment planning to evaluate 54 inpatients, 54 recovering alcoholics, 18 private alcohol and drug treatment patients, 127 college counseling recipients, 272 undergraduates and 19 criminal offenders. Results supported the soundness of the psychometric inventory in assessing the quality of life satisfaction.

Rather, Bruce, C (1991) examined attitude of college students after they were presented with a disease model or social learning view of alcoholism.

Result shows disease model view strengthened endorsement of that model but attitudes toward alcoholics, treatment effectiveness problem recognition and help seeking were not significantly different between the experimental conditions.

Rose Colley, Mary *et al,* (1992) describes Relapse Prevention as therapeutic modality based on Social Learning Theory, used to prevent relapse to individuals who have taken treatment for substance abuse behavior. This study outlines relapse prevention theory and suggests various components of model be incorporated with alcohol education curriculum. It also outlines teaching strategies to implement relapse prevention in class room.

Cooper, Alvin *et al,* (1992) studied the effectiveness of short term group treatment for adult children of alcoholics. For this purpose 24 adult children of alcoholics were tested on measures of loneliness, anxiety, hostility, depression and interpersonal dependency before and after participation in short term group therapy. Findings reveal highly significant test score changes and this supported the effectiveness of individual therapy in short term group treatment.

A research article by Seward, Cynthia A *et al,* (1991) discusses about fetal alcohol syndrome (FAS) areas including causes, common characteristics, secondary characteristics, prevention and treatment. In this article economic implications are noted which suggest that treatment costs are 100 times greater than the cost of prevention programmes.

Fertman, Carl, I. (1991) explored how drug and alcohol aftercare case management service for adolescents (n=18) contributed to maintenance of drug

and alcohol free behavior, adherence to aftercare plans, and participation of schools and families in aftercare plans. They found different patterns of outcome for each of four identified adolescents group. Findings indicated that aftercare did contribute to expected outcomes.

Nelipovich, M. *et al*, (1991) conducted a survey among disabled populations (n=3,216) in Wisconsin concerning alcohol abuse and disability. The result suggests that people with disability consume more alcohol than non-disabled people and some disability groups especially blind or visually impaired consume more than others. Assessment and treatment criteria are proposed.

Rugel, Robert, P. *et al*, (1990) examined participants in alcohol treatment groups (n=28) showed decreases in denial problems associated with drinking and decreases in psychopathology following 12 weeks of group counseling. This study determined greater self acceptance was associated with experiencing acceptance by group and with greater decreases in denial. Decreases in denial and psychopathology were also associated with catharsis, hope and identification.

Timmers, Terri. (1988) developed and tested multimedia nutrition unit for patients undergoing alcohol treatment programme. The context of the instruction was the need of nutrition education. t- Tests showed significant increase in total test score after the instruction suggesting that classes were effective for nutrition information transmission to the clients.

Griffin, John, B. (1983) made a study on the knowledge of medical students about drug abuse problems and patient management on traditional medical board examination. They performed less well on these areas. The best knowledge was of pharmacology of drug abuse, Alcoholics Anonymous, and treatment of delirium tremens and it is found that they knew less about metabolic and biomedical areas, emergency room treatment and legal issues.

Goldman, Mark, S. (1983) had investigated the possibility of reducing cognitive dysfunction and enhancing alcoholism treatment outcomes. It appears that even though the cognitive functioning of many alcoholics remains impaired even after drinking has stopped, considerable recovery can occur.

Walker, R. Dale *et al*, (1983) had tested the hypothesis of different outcome of male alcoholics (n=245) as a function of neuron psychological involvement, aftercare involvement and the duration of hospitalization. Result shows that neuron psychological performance was related to some outcome criteria and there was a strong relationship between aftercare involvements to most outcome criteria.

Cernovsky, Zdenete *et al,* (1983) had done a study on 46 alcoholics who were discharged from a residential treatment programme based on Transactional Analysis for one year. Results revealed that 25 were completely abstinent from alcohol and the other 21 were not drinking excessively as they did earlier. Analysis suggested that the abstinent persons had higher self esteem and were slightly free in expression of their feelings than the other persons.

In a report by Filstead, William, J. (1983) about the conceptual and clinical issues in the treatment of adolescent alcohol and substance misuses, describes a system of care and clinical issues central to service delivery to adolescents with drug or alcohol addiction. This report stresses the importance of adolescence as a critical developmental period and its implications for treatment. They developed criteria to distinguish the most appropriate level of care for the adolescent's clinical condition.

Bartha, Robert. (1982) discussed how a holistic and wellness philosophy becomes a viable alternative to the treatment of alcoholism. This article describes five major dimensions of high level wellness, i.e., nutrition awareness, physical fitness, stress management, environmental sensitivity and self responsibility.

Lovern John, D. *et al*, (1982) have reported utilization and indirect suggestions in Multiple Family Group Therapy with alcoholism. As a component of an alcoholism treatment programme, utilization techniques and indirect suggestion in Multiple Family Group Therapy are described in it. The utilization techniques include: unconscious conditioning, therapeutic binds, indirect suggestions, and the utilization approach. They also described, by using these techniques how we can attain a set of specific goals.

In an article by Gedro, Julie *et al*, (2012) about Recovered Alcoholics and Career Development Implications for Human Resource Development, presents three issues regarding alcoholism, recovery and career development. First, alcoholism is a disease that creates health and wellness problems for

those who are addicted. It also affects individual and work productivity. Second alcohol has a permanent – stigmatization. So those alcoholics who are in recovery stage face challenging choices at the time of self disclosure. Since an alcoholic gets negative image, it is risky to disclose one's identity as a recovering addict. Third, because of such risk or the paucity of research within the field of human resource development around alcoholism and recovery there is a gap in the literature concerning these issues.

Young, *et al* (2011) studied the Personal Construct Theory and the Transformation of Identity in Alcoholics Anonymous. Most of the theoretical approach to alcoholism research presumes linear causal relationships between individual cognitions and behavioral outcomes. This approach failed to account for the recovery of some alcoholics achieved in Alcoholics Anonymous (AA) because AA stresses the transformation of identity framed in terms of relationships rather than cognition and behaviors. George Kelly's personal construct theory (PCT) gives a ready means of theorizing that transformation by describing how AA helps alcoholics to resolve four identity relevant dialectics. The basic postulate of PCT explains changes in stigma: Normal vs. deviant identity. The construction corollary explains changes in perspective: subjective vs. objective view of identity. The individuality corollary informs changes in affiliation, unique vs. common identity and the organizational corollary illuminates changes in stability and fluctuating permanent identity. By focusing on cognition and behavior, PCT facilitates further research in to

alcoholism as a disorder of identity transformation as an alternative to causal approaches.

Ohannessian, Christine Mc Cauley (2012) explored the relations between parental problem drinking, adolescent parent communication and psychological adjustment of adolescents. Survey method was used for the study, in which a diverse sample of 683 (15-17 years old) adolescents in the spring of 2007 and again in the spring of 2008 was examined. Results showed that parental problem drinking directly affected substance use for boys but not for girls. In contrast maternal problem drinking directly affected substance use for girls but not for boys. Adolescent – parent communication also reflected the relationship between parental problem drinking and psychosocial adjustment of girls but not for boys. These gender differences indicate the need to consider both boys and girls of the adolescent and parent when we study parental problem drinking and adolescent adjustment.

Hodge David, R. (2011) conducted a study on Alcohol Treatment and Cognitive Behavioral Therapy: Enhancing Effectiveness by Incorporating Spirituality and Religion is an effective modality for the treatment of alcoholism in cognitive behavioral therapy. This research report orients practitioners to spiritually modified CBT, by incorporating spirituality in to professional treatment and approach that may enhance outcomes with some spiritually motivated clients. More specifically by providing more culturally congruent services by integrating clients spiritual beliefs and practices in to treatment, this modality may speed up recovery, enhance treatment compliance,

prevent relapse and reduce treatment disparities. In this report the process of constructing spiritually modified CBT self statements are described and illustrated and suggestions are given for working with clients spiritually in an ethical manner. This article concludes by stressing the importance of this approach in the face of the growing spiritual diversity that characterizes contemporary society.

Bliss, Donna Leigh (2009) studied the disease model of alcoholism. Since the mid 20th century the disease concept of alcoholism gained prominence as the major etiological model of alcoholism. But it suffers several limitations including its over emphasis on biological factors at the expense of other psychosocial factors; in addition it lacks consistency with a holistic, social work perspective and environment perspective. The increased interest in spirituality among social workers and other professionals call the attention of educators and practitioners to develop a new holistic conceptualization of alcoholism that can incorporate spirituality. Here by using transpersonal theory as a conceptual framework, a spiritual etiological model of alcoholism is presented that compromise the strength of the disease model by allowing for the inclusion of biological determinants of alcoholism which can be taught to students and be utilized by practitioners.

Malone, Stephen, M *.et al*, (2010) conducted a study on mother's maximum drinks ever consumed in 24 hours predicts mental health problems in adolescent offspring background. Here they examined associations between 'maternal maximum consumption' and alcohol dependence respectively and

disruptive disorders and substance related problems in large independent population based cohorts of 17 year old adolescents. The results show maximum consumption was associated with conduct disorder; disruptive disorders in general, early substance use and misuse and substance disorders in adolescent children regardless of sex. Associations were consistent across cohorts providing internal replication.

Haller, Moira *et al,* (2011) studied the unique effects of parental alcohol and affective disorders, parenting and parental negative affect on adolescent maladjustment. Using a high risk community sample, multiple regression analyses were conducted among mothers and fathers, which consist 416 and 346 respectively, to measure the unique prospective influence of parental negative effect on adolescent maladjustment, i.e., internalizing symptoms, externalizing symptoms, and negative emotionality, 2 years later over and above parental alcohol and affective disorders, disruption in the family environment and parenting. Sex wise analyses were also done. Results indicated that maternal negative affect had unique, prospective effect on adolescent internalizing symptoms in girls and negative emotionality in both boys and girls but did not predict adolescent externalizing symptoms. Finding reveals that mother's negative affect have unique effects on adolescent adjustment which are separate from the effects of clinically significant parental psychopathology parenting and disruption in the family environment.

Moderating effects of a craving intervention on the relation between negative mood and heavy drinking following treatment for alcohol dependence

was studied by Witkiewitz, Katie *et al* (2011). The objective of the study was negative affect is an important predictor of alcohol relapse and the relation between negative affect and drinking has been strongly mediated by alcohol craving. The goal of the study was to examine whether a treatment module that targeted craving would predict changes in negative mood during the 16 week combined behavioral intervention (n=776) and the relational changes is mood, craving and changes in heavy drinking during treatment and 1 year post treatment. The result showed changes in negative mood were significantly associated with changes in heavy drinking during treatment. Participants (n=432) who received the craving module had significantly fewer heavy drinking days during treatment and one year post treatment. Moderating effect of the craving module was mediated by changes in craving during treatment period. Pre to post module reduction in negative mood is significant in within subject analyses. More than that post module craving significantly mediated the association between negative mood and heavy drinking during treatment and at post treatment. The conclusion of the study is that the craving module of the combined behavioral intervention may weaken the relation between negative affect and heavy drinking by fostering greater decrease in craving during treatment.

Krohn, Elise *et al,* (2011) made a noteworthy study about Native nutrition at North West Indian Treatment Centre Honors Culture to heal the mind. This treatment centre provides a 45 day inpatient treatment programme in Elma Washington. The squaxin Island Tribe created the programme to

address an unmet need for culturally based drug and alcohol treatment centers for Indian people who grew up on reservations. The programme specialist was treating people with chronic relapse symptoms related to unresolved grief and trauma, such as historic trauma from colonization. The treatment centre weaves culture into the fabric of the programme. According to the reports through this kind of treatment patients must be able to see themselves in their recovery and when their traditions are honored in the healing process retraumatization is less likely to occur. Their culture is their medicine. Native plants, singings, drumming, a sweet lodge, beading, and support from local native spiritual communities are part of the programme. These acts stand like pillars to hold patients up during their recovery. This article also describes the native foods nutrition project which was created by the treatment centre to increase patient's knowledge about high quality foods, including fruits, vegetables and native foods such as berries, wild greens, seafood, and game. Weekend classes teach patients how to grew, harvest, process and prepare these foods. Twice a month tribal elders, story tellers, and cultural specialists speak as part of the programme.

Morrison, Fraser (2011) conducted a study on neuropsychological impairment and relapse following inpatient detoxification in severe alcohol dependence. The assessment was done after a period of three months inpatient detoxification. At the end of a seven to ten days stay in an inpatient alcohol detoxification unit participants were tested on measures of neuropsychological functioning. Then participants were followed up three months later by

telephone to make sure the number of days in which alcohol was consumed during this period using the timeline follows back procedure (TLFB). The design used to analyze the results was correlation and regression. Executive dysfunction during detoxification was found to predict the drinking days in the three months after discharge. Neuropsychological impairment and executive dysfunction seems to be a significant barrier in the ability to remain abstinent from alcohol following detoxification. The high rates of relapse found within the study reveals the cognitive domains that execute functioning describe are relevant in facilitating abstinence in alcohol dependence.

Mental health and substance use characteristics of flight attendants enrolled in an In-patient Substance Abuse Treatment Programme was studied by Horton, Gail (2011). This study was intended to explore the prevalence rates of co-occurring mental health problems among the flight attendants in substance abuse treatment. Results show that flight attendants in treatment were reported more alcohol dependency than drug dependency - More than that a high proportion reported clinical levels of anxiety, major depressive disorder, dysthymia and dependent personality disorder. When analyzed their quality of life they were slightly above average in life satisfaction for a treatment population. Implications for clinical practice were also discussed.

Corrigan *et al,* (2011) studied characteristic of students and services in New York state students assistance and prevention counseling programmes. Data for this study were extracted from office of Alcoholism and Substance Abuse Services Standardized Prevention Activity Summary forms. From 12

high schools at New York State with a total of 407 records were reviewed. The age ranges from 12 to 18 years old with a mean age of 15.5 years is an approximately normal distribution. The students in this sample were referred to services by school sources or were self referred. The most frequently reported reasons for admission were personal problems, family problems, and alcohol or substance use or abuse. Individual sessions were provided to most of the students. The counselors rated services are providing positive changes in every problem areas specifically for adolescents whose parents used alcohol or other substances. The findings of the study reveals positive outcomes for prevention counseling which causes decrease in severity of alcohol and drug use and also the risk factors for alcohol and drug use.

Impact of remembering childhood sexual abuse in addiction recovery for young adult lesbians was studied by Galvin, Christina, R. (2011). This research article examines the impact of childhood sexual abuse on young adult lesbian's sexual identity and their recovery from addiction. The author recommend counselor for sexual orientation both past and present, sexual abuse, and possible dual diagnosis. Implication for the study is also discussed.

Shinebourne *et al*, (2011) conducted a study entitled "It is just habitual:" An interpretative phenomenological analysis of the experience of long term recovery from addiction. This study examines the experiences and understandings of people who are in the process of recovery from alcohol or drug problems over a long period of time. The sample consists of women who have not used alcohol or drugs for 15 years or longer and who describes

themselves as in recovery. Throughout this time they have been involved with A.A. Data were collected by semi structured interviews in conjunction with participant's drawings. Participant's report suggests that their involvement in AA activities over a long period of time evolved in to habitual actions which became a part of their ordinary daily activities. This study provides a basis for future studies using larger samples or different groups towards making more general claims.

Duncan *et al*, (2011) examined development and correlates of alcohol use from Ages 13-20. The sample consists of 256 youth (50.4% female, 51.2% white, 48.8% African American) assessed annually for 6 years. For this a cohort sequential latent growth model was used to model categorical alcohol use (nonuse Vs use). Covariates included in this study are gender, race, income, parent marital status, risk taking, spiritual beliefs, parent alcohol use family alcohol problems, family cohesion, friend's alcohol use, and normative peer use. The alcohol intake trajectory increased steadily with age, friend's alcohol use, and normative peer use was positively associated with higher rate of alcohol intake. Initial parent alcohol use and positive change in parents and friends alcohol use overtime were related to an increase in rate of alcohol consumption from ages 13-20 years.

Forfylow, Andrea, L. (2011) in their article about integrating yoga with psychotherapy: a complementary treatment for anxiety and depression addresses the empirical research on yoga as an effective, complementary, clinical intervention for anxiety and depression based on an examination of

studies published from 2005 to 2010. Research findings support that yoga appears to be an effective clinical intervention for anxiety and depression. This article concludes with practical suggestions and implications to mental health professionals who are interested in using yoga.

Clancy, Sara Elysia (2010) conducted a study on the effectiveness of yoga on body dissatisfaction, self objectification, and mindfulness of the body in college women. Earlier research on self objectification theory suggests that woman may experience self objectification and body dissatisfaction. According to Danbenmeir, Hirrchman (2006) yoga is associated with lower self objectification and lower body dissatisfaction and may be an important intervention toward increasing body satisfaction among woman. The purpose of the study is to determine whether or not a yoga programme has positive effects on decreasing body dissatisfaction, increasing body satisfaction, decreasing self objectification, and increasing mindfulness of the body in college woman. For this study volunteers experiencing dissatisfaction with their bodies and who have zero to limited experience based on their self report were selected for the study. 32 College students were selected for this study and the survey packet consisting of the following measurer. (a) A demographic questionnaire by Clancy, unpublished dissertation, 2008; (b) The Self Objectification Questionnaire (SOQ) by Noll & Fredrickson, 1998, (c) The Surveillance Subscale of the Objectified Body Consciousness (OBC) scale by McKinley & Hyde, 1996; (d) The Body Areas Satisfaction Subscale of the Multidimensional Body Self Relations Questionnaire (MBSRO-BAS; by

Brown, Cash & Mikulka, 1990, (e) The CBBSM by Clancy, unpublished dissertation, (f) The Eating Disorder Inventory – Body Dissatisfaction Subscale (EDI-BD), by Garner *et.al*, 1983 and (g) a modified version of the Frieburg Mindfulness Inventory by Walach, Buchheld, Buttermuller, Kleinknecht & Schmidt, 2006. Participants were randomly assigned to either yoga treatment (Group 1a) or the waitlist control group (Group 2a). After 10 weeks of participation in the waitlist control group, participants from Group 2a then self selected for a yoga intervention Group 2b. In addition a follow-up interview was conducted with 12 participants. Most measures were strongly correlated. A repeated measures analysis was done by combining data from Group 1a and 2b, revealing that participants showed significantly lower within group body dissatisfaction scores and significantly higher body satisfaction scores at post test than at pre test. Participants in Group 1a alone showed significantly higher group body satisfaction scores at post test than at pre test. After 10 weeks of yoga treatment six main qualitative themes were emerged for participants: acceptance, awareness and spirituality, mind-body connection, body compassion, mindfulness of the self, and physical and functional body. Qualitative and quantitative findings give support for the application of yoga treatment for women with body image in a non clinical setting.

Rybak, Christopher (2010) studied about enriching group counseling through integrating yoga concepts and practices. Integrating practices from yoga with group counseling provides many creative path of therapeutic learning. Yoga emphasizes increased sense of connection with the self while

group counseling emphasis increased sense of authenticity in relationship with oneself and with others. The main objectives of yoga and counseling are liberation from suffering through greater awareness and increased integration. Greater clarity of living and deeper sense of relation can provide more positive behaviors and reduced negative consequences. In this study examples are offered regarding the use of yoga principles is various types of groups.

Guenther, Ruth, M. (1981) conducted a study on The Effect of Nutritional Therapy on Rehabilitation of Alcoholics. In this study nutrition therapy was considered as an effective variable in the successful treatment of alcoholism. Research on nutritional needs of individuals has led to an orthomolecular concept which holds the view that each person has unique inherited biological needs. Orthomolecular treatment concentrates to attain the optimum of all nutrients needed by the body specially the brain. For this study a control group of rehabilitation patients who got psychotherapy and an experimental group who got both nutrition therapy and psychotherapy were included. The nutritional therapy consisted of diet modification, vitamin and mineral supplements and nutrition education. One month after the treatment, no significant changes were found between these groups in psychological, medical and self help tests. However after six months treatment 81 percent of the experimental group reported that they were not drinking compared to 38 percent of the control group. Hence a combination of psychotherapy and orthomolecular therapy is found to be more effective.

Hope Focused Interventions in Substance Abuse Counseling is a research article by Koehn, Corinne, (2012). According to this article hope is a vital component of psychological healing and plays an important role in counseling. This article describes several hope focused interventions to substance abused clients to remove the feeling of despair and foster hope in such clients.

Overall view of the review

Only the efficacy of therapeutic interventions in the problem of alcoholic dependency is reviewed here. Studies in these areas give an impression that the psychological, physiological and social factors behind alcoholic dependency are still not very clear. The body chemistry and physiology of alcoholic abuse remain vague and its resultant psychological after effects remain inconclusive. The present study is an attempt to find the efficacy of psycho-nutritional intervention in the cure of alcoholic dependency syndrome.

METHODOLOGY

METHODOLOGY

This chapter deals with the methodology for collecting data. Case study method was used to study the efficacy of psycho nutritional cure procedures for curing alcoholic dependence syndrome.

The therapy intervention programme was held as a therapy residential camping for 7 days and subsequently following the same procedure at home for 40 days, (including the camp period) and a constant follow up was also made through telephone and personal interviews. The data were collected from holistic cure camp held for data collection. This camping procedure was gradually evolved through 15 years of researches held in the Department of Psychology, University of Calicut by Health Psychology Researchers.

Holistic cure camp procedure

Data collection was done by conducting holistic cure camps held at Trivandrum, Calicut and Wayanad districts of Kerala. Clients from other districts also had participated in the camp. Media news announcement and personal contact were done regarding the camps. Details of the camps were printed in detail in notice and the same was circulated among the general public.

The therapy procedure, its rationale, probable outcome and the expenses to be shared by the participants were clearly indicated in the notice. The camps participation was free of cost. But the boarding and lodging expenses of the client and the bystander were met by themselves. Participants who were financially not sound were provided with fully or partially free participation of

the camp through sponsorship of NGO's. The camping is a people movement programme of holistic health.

The camp was initially for seven days. Clients were recommended to follow the same therapeutic procedure for forty days including the camp period. After the residential camp period follow-up meetings were held after twenty days and forty days. As per the news announcements the camp started in an evening. In the first day an introductory lecture regarding the rationale of the therapeutic procedure was given. Personal Data Sheet (Appendix I) was administered to the clients. The most important aspect of the camp was a change from cooked food to uncooked natural diet (yogic diet) and *yogasana* training sessions in the morning and evening. There were no strict disciplines or regimentation in the camp so that the participants could experience a relaxed and friendly atmosphere. However a self imposed discipline was maintained. Effort was given to increase the group cohesiveness in the camp. The participants were allowed to listen to the lectures even in lying position (if they are tired) as sitting leaning their back on walls or in *Suhasana* (sitting with legs stretched forward leaning back supporting hand at back). Self induced discipline was encouraged and tried to make camp atmosphere highly peaceful and cohesive. The rationale regarding the yogic diet and *yogasana* were explained in the first session itself. Raw diet is highly satwik in nature. The digestive enzymes for cooked food and raw diet may be different. By practicing raw diet we can attain humeral balance, it eliminates toxic substances from the body and rectifies problems of internal organs. The most

outstanding effect of the raw food is that it keeps a balanced and stress free psychological state of mind. Such an effect was reported by all clients in the camp. The investigator also experienced the effect of raw eating as the investigator was staying along with the clients in the camp and following the same diet procedure. Eating only raw food can bring such a great change, when mixing with cooked food these changes will be less and the cure rate is slow.

According to holistic health researchers the practice of *yogasana* and meditation are considered to be highly useful psychotherapeutic techniques. The *yogasana* and meditation can bring down to normal range all metabolic activities in the body and give rest and vital power to the brain and associated nervous system.

There are experimental evidences that *yogasana* and meditation bring down the thought processes (the state of *dhyana*), balances the humours and eliminate toxic substances from the body which are helping the cure processes. In order to reduce the emotional and psychological problems of the client's individual and group counseling were also provided. An eclectic approach was used for this counseling.

Collection of personal information and other data

On the first day personal information's about the clients were collected directly since the investigators was also staying in the camp. Their physiological measures were taken in the morning hours of the second day of the camp. Body weight, B.P. and breath rate were measured. The psychological tests were administered in the second and third days after the

lecture classes. Physical tests were repeated at the end of the camp. The level of alcohol dependency was diagnosed by using SADD (Short Alcohol Dependence Data) questionnaire (Appendix –II).

Diet followed in the camp

The subjects were given only raw diet throughout the therapeutic period, all other cooked food was avoided. Compared to naturally cultivated food, artificially produced commercial food has low nutritional value. Chemical fertilizers and pesticides pollute such food and are highly hazardous to health. So naturally cultivated fruits, vegetables, and other raw food, mainly the seasonally available fruits and nuts such as mango, jack fruits etc and fruits which are available in all seasons such as coconut, banana, dates, ground nuts etc were preferred. Fruits available in all seasons have more nutritive value than seasonally available fruits.

Since the personal liking towards the selection of natural uncooked diet is very much related to bodily requirements, the clients were instructed to take natural food which they like much.

Holistic Health Classes

Each day 2 or 3 sessions of classes were given to the clients. The classes were handed by holistic health experts and psychologists, who were specially trained in addiction counseling. The content of the classes were on natural health philosophy, natural diet, disease symptoms, etiology, nutritional cure *(panchaboothas)*, yoga, health psychology, disease concept of addiction, assertiveness training, denial, co-dependency traits, qualities of sober life,

relapse preventions, natural farming and simple living and class about Alcoholic Anonymous were also included.

Psychological Counseling

The subjects were given individual as well as group counseling. Counseling helped them to realize the fact that addiction is a disease, that not only affect the individual alone but it affect family as well as society. The emotional and family problems which are a triggering factor for further drinking were dealt in the counseling sessions. The emotional problems and family problems were relieved in the individual and group counseling. Efforts were made to alleviate their problems in personal discussion and conversations during the group activities of the camp. Client- centered therapy were used so that they could freely associate with the therapist. Cognitive behavior therapy method was used to bring an insight in to the real problems. Denial was also beaked through confrontation and they could regain cognitive consonance. But in some cases an eclectic approach is most suitable to the client.

Artistic Expressions

Artistic expressions mainly music therapy sessions were given to the participants for relaxation and bringing in a meditative atmosphere. Soft devotional songs and light and semi classical film songs were presented by singers. Participation of the group was encouraged. The film songs which are rich in literary and musical qualities, comprehensive to everybody were preferred. This kind of songs was helpful for emotional catharsis. Most of the

participants were voluntarily participated in the cultural activities and wife and children of the participants also took part.

Yoga and Meditation

From the second day of the camp every morning and evening, during the camp period a basic course of *yogasana* training was given to clients and their bystanders. Twenty three *yogasana* postures were contained in this course including *savasana* and meditation based on empirical and experiential insights derived from various *yogasana* courses held in University of Calicut. The yoga course was derived after consulting about the course content with yoga expert in International Yoga Centers in India, such as Kaivallyadham Institute of Yoga, Poona and the Bihar School of Yoga a deemed University-and their authentic books were consulted in the development of the yoga course. This was also presented in national seminars of clinical psychologists to ascertain its clinical value. (Baby J 2004). The procedure and course content of the *yogasana* programme is appended. (Appendix III)

The main feature of this *yogasana* course was that it was more therapeutic in its purpose. Participants were advised to do an *asana* within their ability and capability. Forced final posture was discouraged; only what the participants could do is encouraged. Between all the postures relaxation in *savasana* was provided. And at the end of each session a long *savasana* for five minutes was given. A general instruction of deep steady and slow breathing was given without giving specific breathing instructions. Exercise was not mixed with *yogasana* as exercise is more ‘rajasic’ in nature. Mixing *yogasana*

and exercise is not approved in the traditional system followed here in *yogasana* training. Exercises are helping to warm up muscles while yoga is calming down the nervous system.

Throughout the sessions a Buddhist type of meditation technique of observing breath was instructed. That is paying attention to the air entering the lungs and the air going out of the lungs through the nostrils. According to *Pathanjali* the compiler of *Astanga Yoga Sutra* this can result in to no mind state i.e., *Chitta Vriti Nirodham*. Another important feature of meditation training course was that the participants were instructed to observe silence throughout the session to bring in inner silence and self control.

All the programmes in the camp were held in a co-operative and participatory manner. No strict regimentation was enforced among the camp members.

At the end of the 7 days camp participants were allowed to go home and practice the diet and *yogasana* at home for a period of 40 days including the camp period. Follow up was conducted on 20^{th} day to evaluate the progress and to give necessary tips to improve the quality of their practice. The participants were again gathered on the 40^{th} day to evaluate their progress during these days and gave necessary suggestions to those who reported problems of craving or other difficulties. At the end of this session they were advised to start with spice less and salt less cooked food gradually and initially once a day for one week and twice a day afterwards.

Analysis of data

In this study analyses is done by using case study method, which is purely qualitative in nature. Case study refers to the collection and presentation of detailed information about a particular participant or small group, frequently including the accounts of subjects themselves. The case study looks intensively at an individual as small participant pool, drawing conclusions only about that participant or group and in that specific context.

Here the investigators do not focus on the discovery of a universal generalized truth, nor do they typically look for cause effect relationships, instead, emphasis is placed on exploration and description.

Case study provides a systematic way of looking at events, collecting data, analyzing information and reporting the results. As a result the researcher may gain a sharpened understanding of why the instance happened as it did and what might become important to look at more extensively in future research. Case studies lend themselves to both generating and testing hypothesis. In the present investigation participant observation also was made use of.

Case selection and structure

When selecting a subject, investigator used information oriented sampling as opposed to random sampling.

Case study report

A case study is generally a story, it presents the concrete narrative detail of actual or realistic events and it has a plot, exposition, characters and sometimes even dialogues (Boehrer, 1990).

Relevance of Case Study Method

In clinical case study method retrospective method is used. A type of case study that involves looking at historical information that is to start with an outcome and then backwards at information about the individual's life to determine risk factors that may have contributed to the onset of the illness.

Sources of information used in this research are:

1. Direct observation
2. Interviews
3. Documents
4. Archival records
5. Physical artifacts
6. Participant observation

In the present study case study method would be more appropriate as the problems faced by each individual are unique. However, generalization also is possible in the study of efficacy of the psycho nutritional intervention in the treatment of alcoholic dependence syndrome. Since this research is on a clinical sample case study method is assumed to be more appropriate.

RESULT AND DISCUSSION

RESULTS AND DISCUSSION

The therapy intervention was given to 11 subjects. The results are given in the form of case studies. The following is the first case report.

CASE STUDY REPORT OF CASE - 1

Age	:	41 years
Sex	:	Male
Place	:	Wayanad
Education	:	10th Standard
Occupation	:	Driver in Kerala State Road Transport Corporation
Family Status	:	Married, Mother, Wife and Two Children

Present problem

Alcoholism for 25 yrs, excessive since 6 yrs, using Hans 2 packs daily and chewing tobacco occasionally.

The client started using alcohol when he was 16 years old. He used first time only due to curiosity and peer group pressure. During that period he used very rarely specially on festivals. The quantity of intake was 2 pegs only. Gradually without any particular reason his consumption increased and he used alone as well as in social gatherings. Since 6 yrs he takes most regularly around 500 ml daily. The symptoms like loss of control over quantity of intake and associated behavior, grandiosity, justification, anger and remorse, loss of self esteem, problems at work, breaking up of promises and sometimes

blackout, problems at home, loss of good friends, denial of reality, financial problems, inability to make healthy sexual contact with wife and physical weakness are present. Now he is suffering from liver complaint. All these are triggering factors for further drinking.

He had taken treatment for liver complaint and the doctor advised him to stop alcohol consumption completely but he couldn't stop.

He didn't take any kind of treatment for alcoholism previously.

Now he came to the camp on his own interest.

The major symptoms identified are

1. Loss of control over quantity of intake and associated behavior
2. Grandiosity
3. Justification
4. Anger and remorse
5. Loss of self esteem
6. Problems at work
7. Breaking up of promises
8. Black out
9. Problems at home. (Violent attacks)
10. Loss of good friends
11. Denial of reality
12. Financial problems
13. Inability to make healthy sexual contact with wife
14. Physical weakness

15. Liver complaint

Now he is in the third stage of addiction. His score is 27.

Family background

The client is from a lower class socio-economic back ground. His father was a daily wager and he was an alcoholic too. He died 6 yrs back but his mother alive. He has 4 brothers and 3 sisters. He is in the 6th position. Before five years one of his brothers died due to heart attack. His brothers are occasional drinkers.

About his childhood, he was protected by his mother because of his father's alcoholism. There was quarrel between them most of the time. His father was suspicious of his mother.

About psychiatric history of his family, no diagnosed psychiatric illness was reported. But his father's brother and sister committed suicide. So he might have an undiagnosed psychiatric background.

He is married and it was an arranged love marriage. Married for 17 years and they have 2 children, both are boys of 14 and 17 yrs. They were not separated even for few days as a result of alcoholism. His relationship with family is satisfactory.

Intervention undergone

The camp held in Wayanad district at Sulthan Bathery and was started in an evening. An introductory lecture regarding the rationale of the therapeutic procedure was given in the first day itself. The most important aspect of the camp was a change in to uncooked natural diet and two sessions of *yogasana*

training in the morning and evening. The camps were held in such a way that the participants experience not much restriction or regimentation. However self induced discipline was encouraged. In between awareness classes about alcoholism, diet and yoga were provided. Five individual counseling sessions were given.

The subject came to the camp in a drunken stage. But he was highly motivated in the camp. He attended the lecture class but couldn't sit at a stretch for long time. He was allowed to attend classes in laying position or leaning back on walls stretching legs forward.

In the next morning physical parameters were recorded (Weight, B.P, Pulse and Breath). After that yoga training was given. During that time some sort of restlessness was noticeable. That time onwards raw food was provided. He needed more quantity in the first day. And needed more rest. He could sleep and take rest at that time.

In the forenoon session individual counseling was given. Made him aware of the disease concept of addiction and why he becomes an addict and clarified the difference between a social drinker and problem drinker. He denied at first in the form of minimizing. Stressed the detoxification property of yoga and raw diet and how it can reduce relapse tendency.

He was motivated in the treatment and took initiative to follow the procedures. His body become flexible than before and appetite was reduced to very normal level.

When asked about alcohol craving he reported, first day he had a tendency to drink but now he is in a normal mood and reported no craving.

He seemed to be very happy and he opened his mind more in each of the individual sessions. Eclectic approach was used as a therapeutic technique.

By the 5th day of the camp he was quite normal just like any other normal person. During these days group discussions and musical entertainments were also provided. He was very co-operative in these sessions. In the 6th day a class about relapse dynamics and dry drunk symptoms were given. After that class he admitted that he can't become a social drinker. He was mentally prepared to admit the fact that addiction is a life long disease and the only way to get rid of it is just change the thinking pattern and way of life. And this is the best therapeutic procedure for that.

A telephonic counseling session was given to his wife also.

In between these days 4 major Psychological tests were administered. He was very co-operative in every therapeutic session. The tests were given for feedback sessions of self awareness.

They were advised to follow the same therapeutic procedure for 40 days and recommended follow-up on 20th and 40th day.

On 20th day the subject was quite normal and more pleasant and energetic. He and his wife reported peace and happiness at home. He continued these procedures till that day. There was no relapse. The subject was highly motivated to follow the therapy procedures. An outstanding result of this intervention was the absence of violent behavior.

On the 40th day of follow-up he told physically and mentally he is enjoying the real happiness of life. An inner calm is reported. Now he is less responsive to silly instincts. Most of the symptoms were disappeared. He seemed to be more confident. There was no relapse. The subject was highly motivated.

Asked him to follow the same procedure if there is a tendency to drink and recommended him to take yoga as a part of life and to attend A.A. meeting once in a week.

CASE STUDY REPORT OF CASE - 2

Age	:	51 years
Sex	:	Male
Place	:	Trissur
Education	:	7th Standard
Occupation	:	Welder
Family Status	:	Married, Wife and Two Children

Present Problem

The client uses alcohol since 33 years and excessive since 10 years. Smoking is also present. He started to use alcohol when he was 18 years old. At that time he used very occasionally with his peers. Gradually his consumption increased and since 10 years he uses most regularly around 400 ml daily. There is no particular reason for his alcoholism. Now he is an addict and continuing his consumption. Minor quarrels as a result of alcoholism are present. Financial lose is the main problem due to alcoholism. He is unable to go for regular work and borrows money from friends, relatives and money lenders. He couldn't manage money hence financial burden is present. He has high blood pressure since 1994. Alcohol consumption worsened his physical condition and social life. Now he has limited friends. He had very good social involvement earlier. But now he is withdrawn and not taking active role. He has reported sexual problems, that he has reduced sexual interest. Now for compensating this problem he is using alcohol. He attended a camp before 10 years and stopped alcoholism for 3 years. Again he started and continued till

now. He is highly motivated and impressed in present therapeutic procedures. Low self esteem is another major problem. As a result of this burst out, anger and feeling of guilt are reported.

Major symptoms identified are

1. Increased tolerance
2. Family problems
3. Financial loss
4. Withdrawn from society
5. Poor health
6. Sexual problem
7. Sometimes black out
8. Inability to stop drinking
9. Anger and guilt

Now he is in the last stage of dependency. His score is 26.

Family background

The client is from a poor family and now his father and mother not alive. His father was an occasional drinker. He has 2 brothers and 3 sisters. His brothers are addicts. His childhood was not happy because of poverty.

Due to poverty he didn't go to school after 7^{th}. Then he went for unskilled jobs to look after family.

He is married and that was an inter religious marriage. They have 2 children (girls). His wife's family had not accepted their marriage and after

that they suffered a lot. All these factors increased his alcohol consumption. At present minor family conflicts are reported.

Interventions undergone

The client came to the camp in a drunken stage with his friend. He was really interested in the therapy camp and had partially followed the same therapeutic procedures years back. But that time he didn't get counseling based on addiction. He attended lecture about the rationale of therapeutic procedures in the first day. Since the subject has previous experience he didn't show much adjusts mental problems.

Next day morning physical parameters were recorded and after that *yogasana* training was given. The subject did each and every posture very well. Increased appetite was reported in the first day and he took more rest. But he attended every therapeutic session.

At the time of individual counseling he opened his mind and discussed his problems without hesitation. Denial was not present during therapeutic session and he was willing to make an overall change.

Each day he showed physical and psychological change. He accepted alcoholism is a life long disease and its adverse effects on family.

The subject was very co-operative while doing psychological tests.

Sixth day of the therapy camp, a class about relapse dynamics and dry drunk symptoms were given. So that they can prevent relapse before it occur. It was benefited and he told he got more confidence than before because now only he could understand relapse is a process, not an event. An overall

improvement was noticed at the end of the camp and asked him to follow the same therapeutic procedures for 40 days, continuously.

On the 20th day follow up he seemed to be very happy and energetic. He reported he could control anger and he goes for job regularly. Now he communicates well with his family. He could understand more about his family's problems than before. Some sort of inner peace is reported. The client was motivated to follow the therapeutic procedures. Now he is regular in his works and tries to manage financial matters constructively. Now he is following the therapeutic procedures.

On the 40th day follow up the client and his wife reported overall happiness both physically and psychologically. That time their communication increased and got a structure and system in life and reported decreased tension. His family was very supportive and helping him to follow the therapy. He was advised to follow the same therapeutic procedures whenever there is relapse or dry drunk symptoms. Told him to take *yogasana* as a part of life and advised him to attend Alcoholic Anonymous meeting once in a week.

CASE STUDY REPORT OF CASE - 3

Age	:	52 years
Sex	:	Male
Place	:	Alapuzha
Education	:	10th Standard
Occupation	:	Mechanic
Family Status	:	Married, Daughter (Wife separated)

Present Problem

The client had tasted alcohol when he was 30 years old. He started drinking in his youth hood only due to curiosity. At that time he used 1 or 2 pegs very rarely. Gradually his consumption increased and since the last 10 years he uses excessively and takes all brands about 500 ml daily.

Many problems he faces due to his alcohol consumption. Family problem exists and his wife and daughter have separated from him since 9 months. When asked about this he denied the reason of separation and said since then consumption increased and the condition worsened. There was frequent quarrel between them. The client is suspicious of his wife and he attempted suicide one year before. Destructive tendency is present as a result of his alcoholism. He has no good family relationships and social life is also deteriorated. Even though he is a good mechanic he couldn't go for job regularly. He borrows money from others and couldn't repay. The client tried many times to stop alcohol consumption usually in every New Year but he could not stop. Now he is highly motivated to stop consumption.

Major symptoms identified are:

1. Inability to control his drinking
2. Family problems
3. Denial and justification
4. Occupational problems
5. Family destruction
6. Financial damage
7. Low self esteem
8. Attempted suicide
9. Domestic violence
10. Poor physical wellbeing

Now he is in the 3rd stage of alcoholism. His score is 30.

Family background

The client is from a poor family and his father and mother died when he was very young. He suffered a lot to look after his family since he is the first among 4 children. His relationship with family was good. But now some property issues are reported. No serious physical or mental illness was present in his family.

He is very sensitive, helping and sincere to others but expects the same from them also.

He is married for 10 years and it was an arranged late marriage. Minor issues existed since after his marriage. Now they are separated for 9 month but he said he loves his wife and daughter very much.

Intervention undergone

The client came to the camp in a drunken stage. It was started in an evening. On the first day itself the rationale of the therapeutic procedures were explained. He was restless at that time but present in that session.

Next day morning physical parameters were recorded and after that *yogasana* training were given. The client was highly motivated and he tried to do the *yogasana* postures as far he could. After that raw food were provided. The client followed the procedures strictly and he needed excessive food in the beginning.

At the time of counseling he opened his mind and seemed too much tensed. He loves his family very much and he wanted to rejoin. Consoled him and made him aware of the disease aspect of addiction and how alcohol affected his family life. Even though he accepted his mistakes he told his wife also has committed mistakes. After a long discussion he told he could forgive everything if she comes back with him. He told he wants a life with wife and daughter.

The importance of making a change in his thinking and life style was stressed in the counseling and explained the detoxification property of *yogasana* and raw diet and the importance of counseling for a qualitative sober life.

The client followed each and every sessions of therapy with great enthusiasm. Physically and mentally he changed a lot by the fourth day of camp.

The client was very co-operative while administering psychological tests and showed interest in musical entertainments and singing. In each day of the camp lecture classes related to alcoholism, *yogasana* and diet were provided. So that he could clarify his doubts clearly.

On the 6th day of the camp, class about relapse and dry drunk symptoms were given. So that he could identify symptoms of relapse before it occur.

On the last day of the camp an overall evaluation were done. The client reported complete wellness, and asked him to follow the same procedure till 40 days and then change slowly to the diet as per the directions given in the classes and counseling.

On the 20th day follow-up, the client reported psychological and physical well being. He reported reduced tension, more sleep and he is more energetic than before. That time he could control unnecessary thoughts, so that he has the courage to face challenges. Told him to think positively and deal the problem without alcohol. He told he goes for job regularly and he is hopeful about his future.

On the 40th day follow-up the client seemed to be more pleasant. He was regular in his work and had no tension. He told now he has telephonic contact with wife and daughter and now she is willing to talk to him. Before that she was reluctant to talk. Hence he is hopeful and he reported no craving for alcohol. He practices *yogasana* regularly and keeps regulations of diet also. He reported less anger than before. In general the quality of his life is increased considerably.

CASE STUDY REPORT OF CASE - 4

Age	:	43 years
Sex	:	Male
Place	:	Wayanad
Education	:	5th Standard
Occupation	:	Daily wager
Marital Status	:	Married, Wife and Two Children

Present Problem

The client used alcohol first time when he was 12 years old. He got it from his boss but after that he didn't use until 19 years of age. Initially he used it very rarely. He didn't get any guidance from anywhere since he was the only son and his mother died at the time of his birth. His father remarried after his mother's death.

He becomes violent while takes alcohol and making problems with wife and children. He beats his wife and didn't allow them to sleep at home. He is suspicious of her. Hence they are insecure and many times complained at police station. He makes problems at work place and outside also. He is not taking family responsibilities and physical weakness is also reported. Now he is not able to go regularly for work. Money he gets from job is not enough for drinking. Now he is taking about 450 ml daily and forgets most of the incidents that had happened under alcohol. Every morning he makes promises to wife and children but couldn't keep up his words. He is totally disturbed without alcohol and only to keep normalcy he drinks. Now he is a disturbance to his

wife and children. He has taken an allopathic treatment earlier and stopped for one month. Now the client came to the camp in his own interest.

Major symptoms identified are:

1. Loss of control
2. Violent behavior
3. Physical weakness
4. Problems at job
5. Family damage
6. Financial problems
7. Inability to stop drinking
8. Irresponsibility
9. Suspicious
10. Breaking promises

The client comes in the last stage of alcoholism. His score is 28.

Family background

The client was brought up by his stepmother and has an insecurity feeling since his childhood. His father was an alcoholic and now both are died. He has no close relationships with his relatives.

About his personal area he is very sensitive and loving.

He is married for 21 years and has 2 daughters. That was an arranged marriage. He loves his family very much, but makes violent outburst after drinking.

Intervention undergone

The client came to the camp in an evening and was drunk. He has attended the introductory lecture class in the first day and he was motivated in the therapeutic procedures.

Second day morning physical parameters were recorded and after that *yogasana* practice were provided. The client was restless and reported mild tremors and sleeplessness in the first day. He was co-operative with therapeutic procedures. He started practicing *yogasana*, some problems were there in the initial stage but after that he could do well. After the session raw diet were provided. He needed more quantity on the first day and subsequently took lesser quantity which was sufficient for him.

An individual counseling was given to the client. During that time he discussed family matters. He was motivated and cooperative in counseling and disclosed most of his problems.

Discussed the disease concept of addiction in the first session itself and made him aware of the difference between social drinker and problem drinker and also the co-dependency trait of family members. After that he could accept most of the problems were due to his alcoholism.

After the session the client was decided to stop consumption completely and he accepted that he couldn't control alcohol by using small quantity.

Every day followed the same therapy and in between lecture classes were given. The client changed physically and mentally and he could think positively.

He was co-operative in all psychological tests. Class about relapse and dry drunk were benefited to the client and he could experience the easiness of one day program and advised him to follow the same therapeutic procedure for coming 40 days and to keep follow-up on 20th day and 40th day.

On the 20th day follow-up the client was more pleasant and he seemed to have more insight in to his problem. Violence and suspicion were not present. He was regular at his work and started to repay small debts. That time they were living happily with their limited income.

His wife and daughters were also happy since he is not disturbing them. Now his daughter could study well. He started to take responsibilities at home and could face others without any guilt. For next 20 days told him to follow the same therapy.

Since the client was highly motivated he tried to continue the same procedure. But he reported some skip in between that he couldn't follow diet and yoga completely. Even though he was not relapsed but restlessness and sleeplessness were reported. But he is not going with alcoholic friends and avoiding high risk situations. However he reported mental pre-occupation. Asked him to follow the same procedure strictly for few more days without any gap and told to follow this whenever he feels discomfort.

Recommended to keep counseling for 2 years (once in a month) and attend A. A meeting to improve quality of life.

CASE STUDY REPORT OF CASE - 5

Age	:	55 Years
Sex	:	Male
Place	:	Wayanad
Education	:	10th Standard
Occupation	:	Agriculture
Family Status	:	Married, Wife and Two Children

Present Problem

The client is using alcohol for 37 yrs and excessive since 12 years. Smoking and chewing tobacco are also reported.

He started using alcohol when he was 18 years old only due to curiosity. At that time he used very rarely 1 or 2 pegs only. Gradually his consumption increased and became an addict. But he didn't admit that he is an addict. When asked about his consumption he minimized the quantity of intake as well as problems associated with alcohol consumption. There are minor quarrels with his wife but he did not admit this is because of his alcoholism. Even though he accepts some financial loses are there, here also he justifies the reason of lose other than alcoholism. Sometimes when he uses excessively blackouts were present. He is not able to recollect the events of the previous day, which is a typical symptom of addiction.

He tried many times to stop completely or to reduce the quality of intake but that was a failure. He is not interested in social functions, as he feels that others will blame him. He developed a negative self image and withdrawing

himself from everything. Loss of interest in reading and watching T.V is also reported.

But outwardly he shows grandiosity and feels that he is above all. Now his routines are not proper as he couldn't keep his activities in an order. He feels normal only with alcohol and reported physical problems and poor sexual performance which disturb him since he is a diabetic patient. He had an accident year back. He was attended a similar holistic camp before 7 years and stopped alcohol consumption completely for 1 ½ years. After that he relapsed and could not stop. Now he came for treatment on his own initiative. Wife and children advised him and warned him to stop but he could not.

Major symptoms identified are:

1. Loss of control
2. Grandiosity
3. Blackout
4. Denial
5. Financial indiscipline
6. Social and family deterioration
7. Low self esteem
8. Unstructured life
9. Sexual problems

Now he is in the 3rd stage of alcoholism .His score is 25.

Family Background

The client is from an agricultural family. They had migrated from Thodupuzha when he was 8 years old. His father was a social drinker. He is the third among 7 children and his childhood was not much problematic, but poverty was reported in his younger age. His family relationships were good.

No history of serious medical or psychiatric illness was reported in his family.

About his personal qualities he was a good volleyball player. But due to an accident he became unable to play.

He is married for 28 years and it was an arranged one. They have 2 children both are boys of 24 and 26 years.

Intervention undergone

The client came to the camp in his own interest as he had previous experience in a similar camp. He came in a drunken stage but he was balanced. He was highly motivated and attended the lecture class about therapeutic procedures in the first day itself.

In the next day morning physical parameters were recorded (weight, B.P pulse, breath etc.). Subsequently *yogasana* training was given. In the first session itself the client was almost perfect in doing *yogasana*. After that raw food diet started.

He also reported increased appetite and took more quantity in the first day. Physically he was weak and took more rest.

Counseling sessions were started on that day itself, and discussed the concept of addiction as a disease. Made him aware of the fact that social drinker and problem drinker are different and a problem drinker usually cannot come back to a social drinker. Most of the time he was a good listener and he recognized most of his symptoms with the symptoms of alcoholism.

The researcher stressed the detoxification property of diet and yoga and how it will reduce craving in various discussions and personal counseling.

The client was highly motivated and followed procedures strictly. His body and mind become in normal way, his excessive appetite reduced and he reported relief. He was determined to follow the curative methods and he found to have reduced level of craving for alcohol.

In the counseling session discussed every area of his life, occupational, social, personal, family, financial etc. At that time he admitted and realized most of his present problems are as a result of his alcohol consumption.

He also agreed that no medicine can cure alcoholism. A change in thinking and thereby change in life style is the way to control craving.

An eclectic approach was used in counseling. Total five individual counseling sessions were given.

By the 5th day the client was totally changed and he advised others to follow the therapeutic procedure for 40 days. In between these days' classes about *yogasana*, diet and especially about alcoholism were provided.

In the 6th day class about relapse and dry drunk were given. Told him to identify symptoms before relapse occur.

A telephonic counseling with his wife and children were also given.

In between 4 psychological tests were administered and he was very co-operative in these sessions. Tests were given for feed back sessions of self awareness.

Physical parameters were retested in the last day. They were advised to follow the same procedure for 40 days and asked them to come for follow-up on 20th and 40th day.

On the 20th day he came with his wife and reported that he continues the therapeutic procedure and he is experiencing a real change. He was more pleasant and physically and mentally he improved a lot. Now he got an order in daily activities. He wakes up early morning, and goes for job, takes responsibilities at home and family communication were also improved. More than that he told his guilt feeling was reduced; now he could face anybody without any complex.

On the 40th day of follow-up more changes were noticed. His wife and children were very happy. They started to believe him. So he experiences their love and care in the true sense. He reported dry drunk symptoms at times but then he could manage it easily. No relapse was reported.

Asked him to follow the same procedure when there is craving and as a part of support program told him to attend A.A. meeting and follow 24 hrs programs.

CASE STUDY REPORT OF CASE - 6

Age	:	37 years
Sex	:	Male
Place	:	Wayanad
Education	:	P.D.C
Occupation	:	Agriculture
Family Status	:	Married, Parents, Wife and Daughter

Present Problem

The client started using alcohol when he was 19 years old only due to curiosity. At that time he used very rarely but gradually his consumption increased and since 8 years he uses excessively. He takes 500 ml alcohol and 1 ½ pack cigarette daily and chewing tobacco is habitual.

Alcoholism affected almost every areas of his life. Physical weakness is reported and now he is not able to go regularly for work. He couldn't balance his income with expense. Now he is irresponsible and not takes family responsibilities. The most important problem as a result of alcoholism is his violent behavior. He makes problems at home as well as outside. He is suspicious of his wife and told his alcoholism increased as a result of his wife's problem. Usually he is unable to recollect what happened in the previous day. He borrows money from others and he had lost lots of money and things like, watch, mobile phone etc. His family members especially wife conducted many religious prayers to control his drinking, but he couldn't stop. He is motivated to stop alcohol but now he is helpless. Hence he came to the camp on his own

interest. On the previous day he attempted to murder his wife while drunk and narrowly slipped from the attempt. He is interested in art and literature. He belongs to the aboriginals (adivasi) in Wayanad and he has ability in writing poems and cine scripts. He is highly motivated to complete a script of a film in adivasi language as per a request from a film maker. But he is unable to do the work due to his alcoholism, he said.

Major symptoms identified are:

1. Physical weakness
2. Financial damage
3. Family problems
4. Paranoia
5. Irresponsibility
6. Social problems
7. Discipline
8. Violence
9. Problems at job

Now he is in the 3rd stage of alcoholism .His score is 33.

Family background

The client is from a poor family and his father and mother are alive. Both are using alcohol. He is the last among 4 children. Family problems were present since his childhood. Poverty was also present. His relationship with family members was good. He was brilliant in studies but unable to continue due to poor family set up. He is married for 8 years and that was an

arranged marriage. They have only one daughter. His family life is not satisfactory as he is suspicious of his wife while drinking.

Intervention undergone

The client came to the camp with great motivation. He attended lecture class about the rationale of therapeutic procedure. That time he was little restless and was unable to concentrate.

Next day morning physical parameters were reported. After that he attended *yogasana* training. He was able to do *yogasana* procedures. He followed raw diet and first day he reported increased appetite and ate more and afterwards eating came to normal level.

In the individual counseling session he disclosed all matters without any hesitation. He wanted to stop his alcohol consumption but he was not aware of alcoholism itself is a disease. But after discussion he agreed that he is an addict. He was not aware of co-dependency traits of family members and when he came to know about it he got better understanding about his problems.

Discussed the detoxification property of *yogasana* and diet and how it helps him to keep equilibrium.

He reported mild tremors and insomnia but by the 3rd day his condition improved. After that he got more sleep and regained physical and mental health to a certain extent. His appetite reduced to normal level. He was sober in all way and attended all lecture classes and practiced *yogasana* very well.

He was co-operative while administering psychological tests. His concentration increased and had good grasping power.

On the sixth day relapse and dry drunk symptoms were discussed and provided tips to prevent relapse. The client was enthusiastic and enjoyed the camp period.

A telephonic counseling with his wife was also provided and made her aware of the disease concept and the need of family support to sustain qualitative sober life and recommended to follow the same therapeutic procedures for 40 days.

First follow-up was conducted on the 20th day. The client was sober and some changes were noticed in his life. That time he was more realistic and he could control unwanted thoughts which spoiled him earlier. He practiced yoga every day and followed therapeutic diet also. He was not violent and now he feels guilt for his past deeds. He goes for job daily and started to take family responsibilities. But he reported sometimes he feels mood off but he could think positively at that time. He started to enjoy life and now he could love his wife and child better than before.

He reported his wife also changed and she could understand him more than before.

Told him to follow the same procedure for next 20 days and come for follow-up.

On the 40th day follow-up physically and mentally he was pleasant. He was more energetic and almost regular in his works. No violence was reported. That time he was not suspicious of his wife and no craving to alcohol was

reported. Now he could enjoy life without alcohol. He was regular in his work and could meet expenses by his limited income.

Advised him to follow 24 hours program and follow the same therapeutic procedure when craving occur. Told him to practice *yogasana* every day and also recommended to attend A.A meeting once in a week.

He had a relapse and he excessively drank for about a week and later came back to normal on his own efforts by following the camp procedures.

CASE STUDY REPORT OF CASE - 7

Age	:	48 Years
Sex	:	Male
Place	:	Thrissur
Education	:	7th Standard
Occupation	:	Construction work
Family Status	:	Married, Wife and Three Children

Present Problem

The client started using alcohol when he was 15 years old. He got alcohol from his own home at first time as his father was an alcoholic. At that period he used only due to curiosity. After that he used very rarely and since 15 years he uses excessively. He is very problematic at home always makes problems with wife and children. He is just like an abnormal man under alcohol. He does not take responsibilities at home and not gives money. Everything is done by his wife. He is suspicious of wife while drinking. Anger is also reported. He denies his problems of alcoholism and blames his wife for his problems. His wife complained that he tells lie most of the time and always hides something from her. No mental and physical attachment is present. Now the client decided to take treatment due to family problems and he is taking nearly 400 ml alcohol daily. Now he is withdrawn and not keeping relationships with any of his relatives. He has no close friends also. Anger and irritation are evident in his behavior and has negative attitude towards everybody. Morning drinking is also reported.

Major symptoms identified are:

1. Family damage
2. Physical and mental deterioration
3. Financial problems
4. Paranoia
5. Sexual problems
6. Problems at job
7. Loss of good relationships
8. Law self esteem
9. Morning drinking
10. Blaming

Now he is in the third stage of alcoholism. His score is 28.

Family Background

The client's father and mother are not alive. He is from a poor socio-economic back ground. He is the 4th among 5 children. Poverty was present at his childhood. His father was also an alcoholic. His mother died when he was 2 years old and his grand mother looked after him.

The client suffered a lot at his childhood and he was with bad company when he was a teenager. No history of serious physical or mental illness is reported in his family. He is married and that was an arranged marriage. They have three female children. He had a love affair before marriage and he continued that relationship for few years after marriage. His relationship with family is not good.

Intervention undergone

The client came to the camp by his wife's pressure. When he came to the camp he used alcohol and couldn't attend class.

Next day physical parameters were recorded and explained the rationale of the therapeutic procedure by the researcher. After that *yogasana* practice were given. He was restless and unable to do at that time. Mild tremors and sleeplessness were reported as a part of withdrawal and excessive craving was also present.

After that raw diet was started. He needed more quantity. After that he took rest as he felt tired.

An individual counseling session was given at that day itself and explained the disease concept of alcoholism and explained the co-dependency trait of his family and the detoxification property of *yogasana* and diet therapy. After the individual session he was more co-operative than before. Second day onwards he practiced yoga and followed diet and seemed to be more confident. He was not much irritable and he could understand a lot from the camp. Now he could see others point of view and he was more flexible than first day. He discussed almost problems and accepted the root cause of his problem is alcoholism.

Classes about relapse dynamics and dry drunk were given. Asked him to identify symptoms before relapse occur. Researcher stressed the importance of keeping therapeutic procedure for 40 days and recommended 20th days and 40^{th} days follow-up.

The client came for follow-up on the 20th day and he seemed to be very happy than before. He shared his changes, he told now he could accept his wife and he feels guilty now. At that time he was more confident and no violence or anger outburst were reported. His craving for alcohol was also reduced. He followed *yogasana* and diet till that day.

On the 40th day follow-up he was quite normal. No craving was reported. But he couldn't practice yoga everyday. He followed diet and to a certain extent regained quality in sober life. No relapse was reported. Asked him to attend A.A meeting once in a week and told to practice the same therapeutic procedure whenever there is a tendency and also to take *yogasana* as a part of life.

CASE STUDY REPORT OF CASE - 8

Age	:	26 years
Sex	:	Male
Place	:	Kakkodi
Education	:	10th Standard
Occupation	:	Carpenter
Family status	:	Parents, Brothers and Sisters

Present Problem

The client started using alcohol when he was 17 years old. He used first time due to curiosity and took only 2 pegs in the initial stage. Gradually he consumed more as he had increased tolerance. Now he faces lots of problems due to alcoholism. Most predominant problem is that he is unable to go for job and borrows money from others just for drinking. He is violent and makes problems at home as well as outside. He shows grandiosity by spending money for his friends. Now he has only alcoholic friends. When asked about his alcoholism he is not admitting that he is an addict. He told he has control over his drinking. He justified his actions also. Physically he is very weak not taking food on time. Mostly skips meals. Sometimes he could not recall the events of previous day. He has guilt feelings and now keeps very limited relationships. Without alcohol he could not sleep. But he is highly motivated to stop alcohol.

Major symptoms identified are:

1. Increased tolerance
2. Problems at job
3. Financial problems
4. Violence
5. Loss of good relationships
6. Physical weakness
7. Skipping meals
8. Guilt feeling
9. Sleeplessness

Now he is in the 3rd stage of alcoholism. His score comes 26.

Family background

The client is from a lower class socio economic background. His father and mother are alive. His father is an occasional drinker. He is 2nd among 3 children and no serious family problems are reported. But bad company is the triggering factor for continuing alcoholism.

He is seeking proposals as he is not married but alcoholism is a problem.

About his personal life he is kind and helpful. But mostly manipulate by others. He really wishes to lead a good life. His relationship with his family is good, but they are too much worried about his condition.

Intervention undergone

The client came to the camp instigated by a friend and was highly motivated. He made an attempt of suicide by hanging but failed as somebody prevented. He came to the camp in a drunken stage but he attended lecture class.

Next day morning physical parameters were recorded. He was restless and mild tremors were noticed. Even though he attended yoga practice and practiced simple postures. After that he started taking only raw diet.

An individual counseling session was provided. During that time he expressed his tensions and worries. But he was highly motivated. As a part of cognitive therapy discussed the disease concept and the efficacies of *yogasana* and diet in alcohol cure process. He didn't have severe withdrawal symptoms. But irritability and restlessness were present. Gradually by following *yogasana*, raw diet, group counseling and individual counseling his condition improved. Separate classes about alcoholism and how it destroys a person's overall life were held.

He admitted most of his problems and realized that the only solution is to stop alcohol consumption. Made him clear that addiction is a life long disease and the habit can relapse even though he stops consumption.

The therapist stressed the importance of following the same therapy procedures for 40 days to make a complete change. Before closing the camp a class about relapse dynamics and dry drunk symptoms were provided and told him to take precautions in a daily base. The client changed a lot both

physically and mentally. He was calm. Recommended 20th and 40th days follow up.

On the 20th day he seemed to be more energetic and normal. He was regular in his works and got an order in his life. He told he keeps a distance from alcoholic friends and tries to realize his problems as a result of alcohol consumption. He reported that he feels lonely and boredom sometimes. Told him to be active all the time and go for A.A meeting to get social support. He reported an overall happiness in his life. Advised 20days therapeutic procedure follows up.

On the 40th day follow-up he was very pleasant. Most of the improvements were very conspicuous. His family communication was increased and he started to take small family responsibilities. He doesn't show violent behavior. He told he could mingle with others more freely and no guilt feelings are present. He reported more confidence and said that he feels that he could lead a qualitative sober life. Asked him to follow the same therapeutic procedure when ever there is tension or craving. Recommended to start cooked diet with spices gradually and to take yogasana as a part of life and also to keep follow up at least for 2 years.

CASE STUDY REPORT OF CASE - 9

Age	:	58 years
Sex	:	Male
Place	:	Wayanad
Education	:	Degree
Occupation	:	Agriculture
Family Status	:	Married, Wife and Three Children

Present Problem

The client started using alcohol when he was 18 years old. He used it first time when he was studying for P.D.C and used only for company sake. He continued his social drinking for many years. During that period no problems were existed as a result of his alcohol consumption. He was a hard worker and he looked after his plants very well. Since 6 years his consumption increased and he used most regularly around 300 ml of alcohol daily. But he is not admitting that he is an alcoholic and he thinks he can control his drinking. He justifies alcohol can reduce back pain and he also thinks alcohol will improve his sleep. His wife and daughter advised him many times but he didn't admit that it is a problem. He gets angry when others talked about his drinking. He also reported to have excess cholesterol level. Physical weakness is the main complaint. He attended Art of Living course but didn't stop alcohol consumption. Now he came to the camp on his own interest. The main complaint is about managing family income, since others are manipulating him by borrowing money.

Major symptoms identified are:

1. Increased tolerance
2. Avoid talks about alcohol
3. Anger
4. Denial of reality
5. Physical weakness
6. Justification
7. Tried to stop but couldn't stop
8. Family tension
9. Financial mismanagement

Now he is in the second stage of alcoholism. His score is 15.

Family Background

The client is from an agricultural family. They were migrated from Kottayam. He has 3 brothers and 1 sister and his childhood was happy. His father and mother died years back. His brothers are social drinkers and his relationship with others is good. No serious physical or psychiatric illness is reported in his family.

About his personal life he has the habit of gambling, and had lost interest in reading and other recreational activities which he enjoyed earlier.

About his marital life, married for 32 years and it was an arranged marriage. They are having 3 children, one boy and 2 girls. His relationship with family is good but communication is deteriorated.

Intervention undergone

The client came to the camp in an evening. First day itself he attended lecture about the rationale of the therapeutic procedures. He seemed to be normal except some physical discomfort were present.

Next day morning physical parameters were recorded. After that *yogasana* training was started and he attended that session. But he couldn't do the postures. He just practiced *savasana* due to back pain. After that session class about *yogasana* was given. That day diet therapy was started. He reported increased appetite and the quantity of intake was more.

Then individual counseling was given. He didn't admit that he is an addict. The researcher explained the nature of addiction and its symptoms. Even though he didn't completely agree he was very co-operative with therapy.

Next day morning he tried to do simple *yogasana* postures. Three simple steps were followed. Then took raw food and attended lecture classes. In between he took rest and could sleep well. But he reported sleeplessness at night.

At the time of individual counseling session he got more awareness about his problem and agreed that his alcohol consumption will increase further problems in his life. Gradually an overall improvement was noticed.

He was motivated and decided to stop alcohol consumption completely. He was co-operative in doing psychological tests.

He got more awareness from lecture classes. Class about relapse dynamics and dry drunk symptoms were beneficial to him. Recommended 40

days follow up of therapeutic procedure to reduce craving and to make better cure.

On the 20th day the client and wife reported improved happiness. His physical health improved but reported slight back pain. Sleep also improved. He was practicing the therapeutic procedures till that day. His wife reported an order in his life. No gambling was reported during these days. Physical and mental wellbeing is reported.

On the 40th day he reported he is leading a qualitative life. Unnecessary thoughts were vanished. Now he could think constructively and not goes with alcoholic friends. He realized his mistakes and he could understand others very well. Now he could feel love and care of his family. Now he has no tension and feels that he can overcome his problems smoothly.

Told him to follow the same procedure whenever he has a craving for alcohol and practice *yogasana* daily as a part of life.

CASE STUDY REPORT OF CASE - 10

Age	:	52 years
Sex	:	Male
Place	:	Tirur
Education	:	10th Standard
Occupation	:	Construction work
Family Status	:	Married, Wife and Two children

Present Problem

The client started using alcohol when he was 20 years old by peer group pressure. Initially he took only 1 or 2 pegs occasionally but gradually his consumption increased. Now he uses nearly 500 ml daily. Alcoholism affected all areas of his life; he is not regular in his work. Always family problems are there and family understanding deteriorated. He quarrels at home and always exist problems between wife and children. He likes his son but mostly argues with his daughter as she reacts to his alcoholism. He does not accept his mistakes and always blames others for his shortcomings. He denied the actual quantity of intake and associated problems. Financial mismanagement resulted into a debt of rupees one lakh.

He is short tempered and easily getting hurt if somebody talked against him. He is motivated to stop alcoholism. He is a diabetic patient and not taking care of his health. Not takes proper diet and skips meals commonly. Since 2-3 years he is not capable of making sex with wife.

He took treatment for alcoholism 2 years back but didn't continue medicines as he is afraid that it will affect nerves. He is a musician but alcoholism affected his musical abilities also. Now he came to the camp with family's pressure.

Major symptoms identified are:

1. Increased tolerance
2. Problems at home
3. Not regular at work
4. Physical weakness and thought processes are not normal
5. Anger
6. Blaming
7. Denial of reality
8. Sexual dysfunction
9. No system in daily routine.
10. Financial mismanagement

The client is in the last stage of alcoholism. His score comes 30.

Family back ground

The client is from a poor family with low socio cultural back ground. His father and mother died years back. He is the second among three children. No serious problems were reported at childhood.

About his marital life, married for 26 years and it was an arranged marriage. They have 2 children one boy and girl. He makes problems with wife and daughter. His alcoholism affected his family life.

Intervention undergone

The client came to the camp with his family's pressure, even though he had inner motive to stop alcohol consumption. He was restless and showed irritability. He questioned each and everything. He attended the introductory lecture class about the rationale of the therapeutic procedures.

Next day morning physical parameters were recorded. After that *yogasana* practice were started. The client was highly motivated in practicing *yogasana*. He practiced postures as he could, after that took raw food. He did not show any problems to follow in therapeutic procedures, but restlessness and irritability were noticed. Mild tremors and lack of concentration were present. Sleeplessness was also reported along with symptoms of anxiety.

At the time of individual counseling he disclosed most of his problems but he blamed his wife and daughter for most problems at home. He told he can stop alcohol at any time but family is the triggering factor. He feels that they are not respecting him and not obeying him.

Discussed the disease concept of alcoholism and explained each and every symptoms and characteristics of an alcoholic person. Made him aware of how a social drinker differs from a problem drinker.

He could understand everything and accepted some problems. Discussed co-dependency traits of his family developed as a result of his alcoholism.

He had no knowledge about alcoholism before and after the discussion some changes were present in him. He needed more rest and he was lying after therapeutic sessions.

He attended all sessions and showed more interest in therapy than before. He was co-operative in psychological tests also. After 3-4 days physically and mentally he was calm and reported more sleep than before. Now he could control his thought process also. No craving for alcohol was reported. Now he could realize his problems to a certain extent.

His family was supportive in treatment. He was impressed with treatment procedures and was ready to follow the same for 40 days.

On the sixth day a class about relapse and dry drunk symptoms was held. Trained him to take precautions to prevent relapse in a daily basis and also trained assertiveness skills as a part of personality development.

At the end of the camp lots of changes were noticed both physically and mentally. Recommended 20th days and 40th days follow up.

On the 20th day follow up he came with more enthusiasm, he was most normal and regular in his works. Now he could love his family and improved communication. He practiced *yogasana* and diet daily, initial physical weakness reduced to a certain level and he does not blame others. He could look within and realize his mistakes. Told him to take daily treatment and attend A.A. meeting once in a week.

On the 40th day follow up his wife and children, reported great change. They were very happy and the client was also enjoying his sober life. Violence

and irritable nature were not present. He takes family responsibilities and able to satisfy family's needs by limited income. No relapse was reported. Asked him to come to the cooked food gradually and follow *yogasana* training everyday. To improve quality of life recommended 2years follow up.

CASE STUDY REPORT OF CASE - 11

Age	:	17 years
Sex	:	Male
Place	:	Calicut
Education	:	9th standard
Occupation	:	Fisherman
Family Status	:	Unmarried, Parents Brother and Sister

Present Problem

The client started using alcohol and ganja when he was 11 years old. He started ganja first then gradually turned in to alcohol. His father is a heavy alcoholic, so he had an opportunity to drink in his very younger age. At first he used very rarely, gradually his consumption increased, now using 350 ml daily.

The main problem as a result of his alcoholism is that he is violent, and destroys things at home. He is quarrels with father and mother and physical assault is present. He couldn't stick on any job for long time; he quits every job within weeks. He makes money in an immoral way i.e., takes money and things from those people who are unconscious under alcohol. Many police cases were registered against him. He is not admitting his problems, but his family members disclosed his problems.

The client really wanted to stop alcohol consumption but he couldn't. He is very aggressive and he couldn't control himself. Physical problems are also present. Dizziness and convulsion were reported and had taken homeo treatment earlier. But he didn't stop alcohol consumption. Now the client came

to the camp with his family's pressure. His attitude is ambivalent.

Major symptoms identified are:

- Violent and destructive behavior
- Not going for job
- Ethical breakdown
- Family problems
- Physical problems

Now he is in the third stage of alcoholism. His score is 25.

Family background

The client is from a lower class socio cultural back ground. His father and mother are alive. His father is a fisherman. He is the eldest among three children. He has one brother and sister. His sister married but divorced. He is very irresponsible, not goes for regular job or gives money at home.

He is not married. No premarital relationships are reported.

Intervention undergone

The client came to the camp in the evening under alcohol. He couldn't sit or listen to the camp since he was restless.

Next day physical parameters were reported and *yogasan* training was started. With pressure he came to the yoga class but followed the postures as per the instructions. After that raw food was provided but the quantity of food taken was very low. At that time he was restless and sleeplessness was his main problem.

After that an individual counseling session was given. At that time he disclosed very little, but showed interest to stop consumption. Some misconceptions were present and that was cleared after discussing disease concept of alcoholism. He didn't show any motivation in life at the first day.

But the contradiction was that, he followed the therapeutic procedures strictly. 3rd day onwards some sort of improvement both physical and psychological aspects were noticed. He did *yogasana* well than before and he was co-operative. He was enthusiastic in psychological tests. His concentration increased and he was punctual in each therapeutic session.

In between 5 individual counseling sessions were given. Also gave an opportunity for group discussion. In each counseling sessions he disclosed many feelings and problems and he admitted the root cause of all these problems are alcohol. He reported no craving. As he is very young physical weakness were not evident.

By the 6th day he was truly motivated to stop alcohol consumption and was ready to follow the therapeutic procedure for the coming 40 days. That day a class about relapse and dry drunk symptoms were given. The client was totally changed in the 6th day.

On the 20th day physical and mental changes were noticed. He was more hygienic and his parents reported, no violence and he go for job regularly. He didn't go with bad company. He followed diet and yoga nearly 15 days after 7 days camp. But not relapsed.

Asked him to restart the procedure to improve quality of life and thereby reduce tendency to drink. An over all happiness was reported. On the 40th day follow up he told again started to follow therapeutic procedure and now he started doing *yogasana* regularly but couldn't keep diet. He feels better and reported total calm. Now he could see the positive side of life and he has some goal in life. Still he is not going with alcoholic friends. He has reported an order in life and going routines in a structured way. Quality of life is increased.

SUMMARY AND CONCLUSION

SUMMARY AND CONCLUSION

All the 11 cases reported in this study are having several similarities. All these cases were highly motivated to have a cure and they had come for the therapy camp with a very strong motivation for stopping their alcoholic tendency. A few of them were having addiction for some other substances, such as ganja, panmasala, tobacco etc. The recovery rate was very high in this psycho nutritional therapy intervention. The recovery rate in conventional de-addiction methods of Allopathic – Psychiatric method is somewhere near 30% and that too happens where counseling has a major role in the cure process in the case of strongly motivated subjects. The efficacy of the Psycho nutritional method is very conspicuous in the case of all these 11 subjects. A follow-up was made before writing this discussion that is after 7 months after the therapy intervention reveals that a relapse was not taken place any of these cases. It is possible that a total positive transformation might have taken place in the attitudes and personality make up of these subjects. The investigator wish to attribute this positive effect mostly to yogic diet, *yogasana*, psychotherapy and other group dynamic interventions to the curative process of alcoholism.

The psycho nutritional intervention strategies employed in this therapy camp was derived from several such earlier camps, held as a people movement by the holistic health researchers of the Department of Psychology, Calicut University. The present camp was held collaboratively with the expert's health activists. The yoga session in the morning and evening for 1 hour each were

reported to be so effective in maintaining mental control and reducing the problems associated with alcoholism. The effect of yoga was multiplied in to many folds as it was done during completely in yogic diet. The classes on holistic health were taken immediately after the yoga session when the patients were completely relaxed and highly receptive to such therapy methods. The organizers of this camp and the investigator had early experience in the procedures of this camp as a part of our social service activities.

Counseling given individually to all the patients found to be very effective. The resolution of their problems was highly conspicuous from their verbal and nonverbal feedback at various stages. The efficacy of such psychotherapeutic counseling was increased in to many folds as the subjects were in yogic diet and undergoing many *yogasana* and meditation intervention. The counseling sessions have definitely brought more insight into the problems of alcoholism of each patient, they said, they were ignorant about the various stages, and aftereffects of alcoholism.

As per the philosophy of the psycho nutritional intervention it is the toxic substance in the body responsible for the addictive behavior. Since the raw food method results in to a complete detoxification of the body especially in the blood, addictive tendency will be to a great extent removed. In traditional nature cure method addictive behavior like tobacco and such other substances are removed by employing the method of fasting. While fasting, the toxic substances such as alcohol and tobacco will be completely eliminated from the body resulting in to a reduction in the addictive behavior. Resorting

completely on raw food also has similar effects like that of fasting. One important fact to be remembered in this context is that the digestive enzymes required for the assimilation of raw food and for cooked food are different. So a total biochemical environment is brought in the body when completely on raw diet. A mixing of cooked food and raw food can confuse the stomach and the digestive enzymes which may result in to comparatively low rate of recovery. So a total bodily change can be brought by completely on raw food along with a remarkable change in consciousness and behavior. Subjects undergoing raw food therapy often reports that their mental status is serine, calm and controlled. Their thought rate per second is reduced which can be attributed to the yogic state. All the psycho nutritional intervention strategies were collectively contributing to the recovery from alcoholism.

Conclusion

From the present investigation of psycho nutritional intervention for alcohol dependent syndrome, it can be concluded that raw diet therapy (Yogic diet), *yogasana*, psychological counseling and such holistic therapy interventions are found to be very efficient in the cure of alcohol dependent syndrome.

Limitations of the study

1. It was extremely difficult to get motivated subjects for this therapy intervention. So the conclusions are derived from a low sample.
2. The raw food produced through nature farming was most ideal for this therapy intervention. However the availability of such food material

was difficult. However, attempts were made to completely eliminate the pesticides and other chemical toxins from the raw food material.

Scope for further research

1. The study should be conducted on a large sample with the help of finance supporting agencies.
2. The efficacy of psycho nutritional intervention should be propagated professionals in the field of de-addiction.
3. More advanced studies on de-addiction should be done different samples using different therapy interventions to assess the efficacy of each intervention.

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APPENDICES

APPENDIX I
PERSONAL DATA SHEET

Date of Reg. ..... Case No.:.....I.P. No.....
Place of Regn. Centre/Field ..... Regd. by .....

1.	Name	:	..... 2. Sex:M/FM
3.	(a) Age..... 3.(b) Age category: 12-17/18-23/24-30/31-45/46-60/61+		
4.	(a) Address – Permanent	:	....
4.	(b) Addres-Temporary	:	....
5.	(a) Religion	:	Hindu/Muslim/Christian/Others 5(b) Caste (if any).....
5	(c) Religion Category	:	GC/OBC/SCST
6.	Education	:	III/Lit/up to prim/upto midl/upto sec/upto Hs/upto DC/upto PG/Rec/Prf/Tech/Any other .....
7.	(a) Family: Type	:	Nuclear/Joint/Extended
7.	(b) No. of members in the household	:	Adults, Males..... Females..... Children... Males.....Females..... ..... Specify (.....)
8.	Place of residence	:	City/Town/Sub Urban/Rural
9.	(a) Marital Status	:	Mar/Unmar/Wid/Widr./Div/Sep/Remar
9.	(b) If married No. of children	:	Nil/Males ..... Females .....
10.	a) Family Tree	:	

Name of family members/Support person:\
Address: ..... Tel No.....
.....
.....

10	(b) Occupation	:	Currently unemployed/Self-employment/ Not Known, Never employed/Part-time employment/Full time employment
		:	House wife/Student/Pensioner
10	(c) Employment Category	:	Govt. Busi/Agrii Labr/Profl/Tech/Transp/ Riksha/Scoo/Auto driver/Any other
11.	Monthly income	:	Nil/Rs.500-1000/1001-3000/3001-5000/5001-10000/10001 & above + (Specify Rs.....)
12.	Family income	:	NIl/Rs.500-1000/1001-3001-5000/5001-10000/10001 & above + (Specify Rs.....)

1. **ADDICTION HISTORY**

13.	Drug Abuse	:	Single drug/Two Drugs/Multiple drugs
14.	Types of drugs used	:	A Narcotic-Analgesics Opium/Morphine/Heroin Brown sugar/pethadine/Methadone B. Stimulants Amphetamines/Cocaine C. Depressants Barbiturates/Alcohol/Sedative-Hypnotics D. Hallucinogens LSD/PCP E. Cannabis Ganja/Marijuana/Charas/Hashish-Bhang F. Any other/Others
15.	Length of usage	:	Below 1 year/1-2 year/above 2 years (Specify exact Period.....)
16.	Causes of addiction (Reported by client)	:	Premorbid Personality/Anxiety/Depression /Frustration/-Loneliness/ Curiosity/Peergroup Pressure/Ind. Probs/Family Probs/Anyother .....
17.	Source of Referral	:	Self/Family/Friends/Medical Practitioner/ Nursing/Home/Hospital/Social Worker/Any other .....
18.	(a) Previous Treatment for addiction	:	Yes/No
18	(b) Type of treatment	:	Allopathy/Ayurveda/Homeo/Others
18	(c) Place of treatment	:	Private Psychiatrist/Private Psychologist/ De-addiction Centre/Mental Hosp/ Gen. Hosp/ Private, Hosp/Prim. HC/ Any other .....
19.	(a) Abstinance History	:	Yes/No
	(b) Period of Abstinance	:	3 months/6 months/ 1 year/ 1 ½ years/ years
	(c) Reasons for Relapse (reported by client)	:	.....
20.	(a) Contact Person Name	:	..... 20. b. Age..... 20c Sex M/FM
20.	(d) Relationship to Patient	:	.....
20.	(e) Address	:	..... Phone: .....

Clinical Examination result at admission

21. (a) Body weight..... Kg (b) BP .... (c) Breath rate .....(D) Pulse.....

Clinical Examination result at discharge

22. (a) Body weight..... Kg (b) BP .... (c) Breath rate .....(D) Pulse.....

REMARKS

Date: ..... Investigator

APPENDIX II

SADD - SHORT ALCOHOL DEPENDENCE DATA QUESTIONNAIRE

INSTRUCTIONS: The following questions cover a wide range of topics to do with drinking. Please read each question carefully but do not think too much about its exact meaning. Think about your MOST RECENT drinking habits and answer each question by circling the MOST APPROPRIATE heading. If you have any difficulties ASK FOR HELP.

	Never	Sometimes	Often	Nearly Always
1 . Do you rind difficulty in getting the thought of drinking out of your mind?	0	1	2	3
2. Is getting drunk more important than your next meal?	0	1	2	3
3. Do you plan your day around when and where you can drink?	0	1	2	3
4. Do you drink in the morning, afternoon and evening?	0	1	2	3
5. Do you drink for the effect of alcohol without caring what the drink is?	0	1	2	3
6. Do you drink as much as you want irrespective of what you are doing the next day?	0	1	2	3
7. Given that many problems might be caused by alcohol do you still drink too much?	0	1	2	3
8. Do you know that you won't be able to stop drinking once you start?	0	1	2	3
9. Do you try to control your drinking by giving it up completely for days or	0	1	2	3

weeks at a time?				
10. The morning after a heavy drinking session do you need your first drink to get yourself going?	0	1	2	3
11. The morning after a heavy drinking session do you wake up with a definite shakiness of your hands?	0	1	2	3
12. After a heavy drinking session do you wake up and retch or vomit?	0	1	2	3
13. The morning after a heavy drinking session do you go out of your way to avoid people?	0	1	2	3
14. After a heavy drinking session do you see frightening things that later you realize were imaginary?	0	1	2	3
15. Do you go drinking and the next day find you have forgotten what happened the night before?	0	1	2	3

Scoring: The 15 items summed for a total score than can range from 0 to 45. Scale totals are interpreted as follows: 1-9 low dependence, 10-19 medium dependence, and 20 or greater high dependence.

****

Short Alcohol Dependence Data Questionnaire (SADD)

Author/Developer:

Raistrick, D., Dunbar, G., & Davidson, R., (1983). Development of a questionnaire to measure alcohol dependence. British Journal of the Addiction, 78, 89-95.
D. Raistrick, M.D.
Leeds Addiction Unit
19 Springfield Mount
Leeds, LS2 9NG U.K.

The SADD can be used without charge.

APPENDIX III

RELAXATION: THE YOGASANAWAY

A SELF HELP MANUAL FOR THERAPISTS AND TRAINERS

There are altogether about 108 methods of yogasana training. Only slight variations are observed in these methods. One asana can have various versions. The present self help manual describes 23 postures of a basic course. The course is designed based on empirical and experiential foundations. The following are the salient features of the course.

1. The participants are instructed to observe silence (*mouna*) during the entire session.
2. Participants are allowed to breath according to their requirement. Slow deep and steady breathing is encouraged. No any specific instruction for inhale or exhale.
3. A zen meditation technique of observing breath is merged in the asanas.
4. Mixing of bodily exercises with yogasanas is not allowed.

Introduction

Yoga is derived from TANTRA an ancient time-tested science describing different systems for increasing the speed of human evolution. The Sanskrit word '*Tan*' means 'expansion of consciousness' and '*tra*' means 'liberation of energy'. The merge of tantra with the philosophy of Vedanta formed the system of Yoga (Saraswathi, S.S., 1983). Yoga and tantra do not belong to India, but a common inheritance of all mankind. The tantric philosophy and belief is to let the mind be, for what it is and where it is, not to interfere. There is no need to fight with the mind, follow it and know it well.

According to tantra and psychology we must observe analyse and respect whatever thoughts or experiences come to our mind. The aim of *tantra* is to liberate the mind from the bonds of matter *prakrithi* that is from patterns, formations and impressions. Religions restrict us from 'bhoga' but tantra says *yoga* and *bhoga* should be integrated.

Yogasanas lead us to *Dhyana* (meditation) through the stages of *Prathyahara* and *Dharana*. The classical definition of meditation in Patanjali's *Yoga Sutra* is that

'when the mind has been able to transcend the knowledge of smell, sound, touch, form and taste and at the same time when the consciousness is functioning around one point'. Concentration is not *dhyana* but the way to *dhyana*. There are no techniques for dhyana. It is a state that arises spontaneously. Yogasanas and meditation are intended to bring about that spontaneous state of *dhyana*.

Yoga is union – the integration of body mind and psyche through heumoural and hormonal balance, elimination of toxic substances from body, increased blood circulation, and alerted immune functions through proper dispersion of *prana* all over the body. Individual transformation through experiencing is more important than intellectual reading or discussing on yoga.

It is always better to learn yogasanas from a teacher (*guru*). But it is not impossible to learn Yoga from properly prepared audio, video and print media devices. The success depends on your motivation and enthusiasm. Be very *careful* about the following:

1. Judge a teacher for his yogic personality. Avoid professional *gurus* and showmanship groups.

2. All movements should be slow and steady (as if the slow motion in movie) without any jerking, shivering and wavy motions. Excess, sweating, reddning of eyes, back pain, cramps and unhappiness after doing asanas are indicative of wrong-doing. However such problems are likely in the initial stages of training.
3. An asana should be done in physical and mental relaxation. More relaxation leads to more perfection in postures.
4. Yoga is opposite of ego. So the psychological transformation is more important than bodily postures. Do not approach yoga as a bodily exercise.

GENERAL INSTRUCTIONS

1. Do yogasanas on a mat or sheet (non synthetic) in order to avoid earthing of the energy converged in body.
2. While practicing asanas in group, please do not look at other participants and make comparisons. Follow instructions from the teacher and see demonstrations.
3. Do not do asanas when you are ill, extremely tired or upset. However tiredness and mental upset can be relieved by Savasanam and meditation. Avoid asanas during menstrual periods.
4. Avoid asanas after a heavy meal. Practice asanas at least 4 hours after a meal. This restriction is not applicable for those who live on raw food alone (fruits, nuts and vegetables in the uncooked form).
5. Morning around 5 to 6 is an ideal time for yogasanas. Evening sessions also can be held.
6. Yogasanas should not be a torture or violence on body and mind. Limit practice according to your mental setting.

7. Practice nonviolence (*ahimsa*) on all creatures and extend awareness to immediate and distant surroundings and nature.
8. Reading the writings on the Budha and the works by Jiddu Krishnamurthy, OSHO, Remana Maharshi, etc will accelerate the transformation in us.
9. Practice yogasanas in empty stomach after defecation. But if you have problem of constipation, do not bother, yogasanas will rectify the problem.
10. Avoid animal food, stimulants and intoxicants. If you find it difficult, do not worry. Yogasana practice will help you to avoid them.
11. The effect of yoga in you can be realised by the development of virtues in you along with the improvement of postural perfection.
12. Many people ask whether stopping yogasana practice will adversely affect their health. No. No harmful effects. But you will not get the benefit of it. That is all.
13. You can limit your asanas to a few which you like the most, especially when you have less time for practice. However in such situations the number of forward-bending asanas and backward-bending asanas should be almost equal. The sequence of yogasanas in this is made accordingly.

INSTRUCTIONS FOR INSTRUCTORS

1. The instructor should sit in Padmasana while giving instructions. He should be very alert, calm and relaxed. He should be visible to all participants and all participants should be visible to him.

2. The tone of instruction should be pleasing and gentle. Harsh tone and words should not be used. Instructions should be natural and genuine. Elongating a word may induce hypnotic trance (especially in Savasana) which should be avoided. Hypnosis is anti-yogic (Refer Swami Vivekananda for details).

3. Your instructions should be minimum and well edited. Too much of talking should be avoided. After the first three or four sesions instructions should be the bare minimum so as to enable the participants to experience silence. Once they have grasped the details you need announce the name of the asana by 5^{th} or 6^{th} session onwards.

4. Silence should be induced throughout the session. Tell the participants that talking and doing asanam is harmful. Discourage a participant if he indulges in conversation. Request him to voluntarily control his tendency to talk.

5. Request the participants not to look at others (including the instructor) while doing an asana. In a posture if you turn your head to look at another person it becomes a wrong posture which may be harmful.

6. The demonstration of postures whenever necessary can be done by the instructor or another expert in front of the instructor. You can make use of a participant who is good in postures for demonstration. If the instructor himself is demonstrating he should avoid talking while demonstrating.

7. Usually this basic course should be held for 10 continuous days. The 23 postures should be taught in the first 6 sessions and the next 4 sessions should be used for corrections of postures. *First Session* - postures 1 to 6. *Second session* - postures 1 to 8. *Third session* - 1 to 12. *Fourth session* - 1 to 16. *Fifth session* - 1 to 18. Sixth session 1-23. Before closing each session Savasanam should be given for 3 to 5 minutes followed by the zen meditation for 2 minutes and then chanting the OMKARA Manthra three times.

8. This course can also be held in 3 days or in 5 days camps. If so there should be evening sessions too. Postures may be taught in the first 5 sesions and follow up sessions may be held afterwards for corrections of postures (Courses can be held for two day's sessions per week for 5 weeks).

9. During the first two-three sessions each asana can be repeated twice or thrice. But by the third session learnt asanas need be done only once in order to keep up time.

10. Yogasana postures should be self-initiated movements. The instructor should not support or lift any body part of the practitioner. As far as possible, the instructor should not touch a practitioner except on falling or locked up position. (Supporting body on wall also is wrong).

BEGIN THE YOGA SESSION

Arrange the Yoga session in a calm, airy and safety-feeling place where all the participants should be visible to the instructor.

INSTRUCTIONS

This is a basic course of 23 postures. We will begin with a ZEN meditation for calming down. We will not be mixing any bodily exercises in this course. Exercises are predominantly for muscles for *warming up* but yoga is for the mind and is aimed at *calming down*.

Sit in Padmasana or Vajrasana (need not be in its perfect posture in the beginning) or sit cross legged comfortably and relaxed. Spine erect. Have a pleasant face which indicates relaxation. Slowly you close your eyes. Deep breathing long steady breathing without making noise audible to others and without too much stretching of the chest. When you sit in such silence all sorts of thoughts may come to your mind. Please do not try to control your thoughts. Let the thoughts come and go. You pay attention (not concentration) to the air entering your lungs and going out of the lungs. Continue observing this breathing in relaxed body for about two minutes. (Always practice asanas only after this ZEN meditation).

1. ARDHA HALASANAM - A
(one leg each)

Do yogasanas with pleasant face and relaxed body

Lie on your back (supine position) legs close ... hands stretched close to body ... palms down towards floor ... head straight. All movements should be slow and uniform. No wavy motions shivering and jerks. Slowly raise right leg without bending the knee and stretching the toes forward. Raise only upto 45 or 50 degrees . . . not more than that (while raising the right leg, your left leg and other parts of the body should be relaxed). Remain in that position for a while and slowly bring down the right leg. All movements should be slow and steady. Now slowly raise the left leg without bending the knees and stretching its toes forward. Remain in that position for a while and bring down slowly. Keep the right leg and others part of the body relaxed while raising the left leg. Let your face be pleasant. Breathing slow and steady without much noise as per your requirements.

BRIEF SAVASANAM TO BE DONE IN BETWEEN EVERY POSTURE

Lie on supine position .... legs a little apart .... hands apart .... palms upward .... turn your head to left or right. Slowly close your eyes. Relax your entire body ... no tension anywhere in the body ... loosen every part of the body. Breath slowly and deeply and steadily (without making noise audible to person sitting near you). Take long breaths and observe breathing. Pay attention to air entering the lungs and going out of your lungs. Do not control your thoughts ... observe breathing ... feel the air entering and going out of your lungs in complete relaxation. You can avoid thoughts by observing breaths.

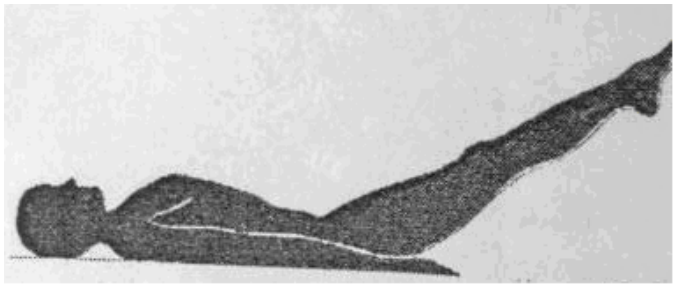
***Note*:** The duration of this brief Savasanam after every posture may be limited according to the availability of time for you. In the initial stages of practice you may require one or two minutes and after attaining mastery you may need less time.

2. ARDHA HALASANAM - B

(Both the legs together)

Lie down on back ... legs close ... hands close to body .... palms down. Head straight. Slowly raise both the legs together without bending the knees and keeping the toes

stretched forward. Raise only upto 45 or 50 degrees ... not more than that. Remain in that position for a while and bring down very slowly. Now relax in savasana. While raising the legs all other parts of the body should be relaxed.



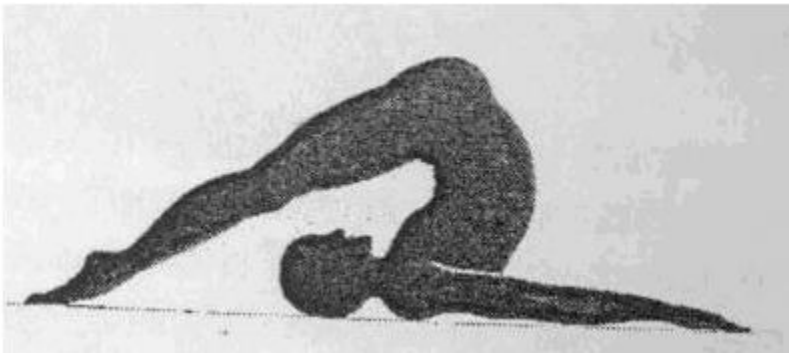
Breathing slow and steady as per your requirements. All movements should be slow and uniform without waving shivering or jerking.

Relax in Savasanam.

3. POORNA HALASANAM

Lie on back, hands close to body palms down ... legs close ... raise both the legs without benting the knees and stretching the toes forward ... and bring the legs behind your head by raising the buttock and bending the spine. Do not struggle for the final posture. Do only up to what you can do. Overstraining is harmful. Now remain in savasana.

The instructor in group session should be vigilant and should help if any individual is unable to bring back his body to the earlier position. Instances of participants struggling in locked up condition may happen.

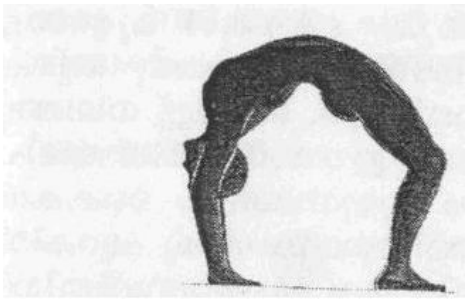


Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

4. CHAKRASANAM

Lie on back. Keep your legs slightly apart and fold them bringing the heels near your buttok. Raise your hands and place it behind shoulders keeping the palms on floor ... fingers towards the shoulders. Slowly raise your buttok first then abdomen, chest and shoulder area and then your head. Remain like an arc and loosen the neck and keep the head hung. Remain in this final posture for a while and come down very slowly ...

bring down the head and touch it the floor and then the shoulder and chest area, the abdominal area and finally the butok. Unfold the legs and bring back the hands.

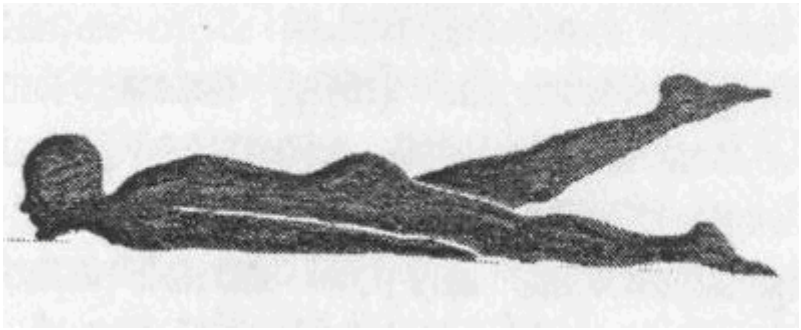


Breathing slow and steady without making noise as per your requirements. Relax in Savasanam.

5. ARDHA SALABHASANAM

(one leg each)

Lie on stomach stretching the entire body ... hands close to body ... palms upward tuck below your thighs. Rest your head on chin. Straighten your head so as to bring your gaze parallel to the floor. Slowly raise your right leg (45 or 50 degree only) without bending the knees and keeping the toes stretched back. Remain in this final position for a while and bring down the leg slowly. When the leg is raised all other parts of the body should be relaxed. Repeat the same with the left leg.

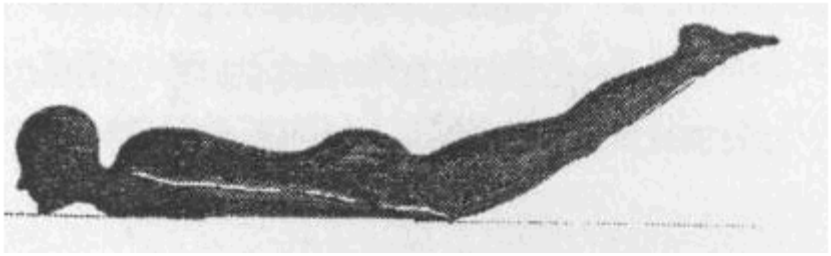


Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

6. SALABHASANAM

(both the legs together)

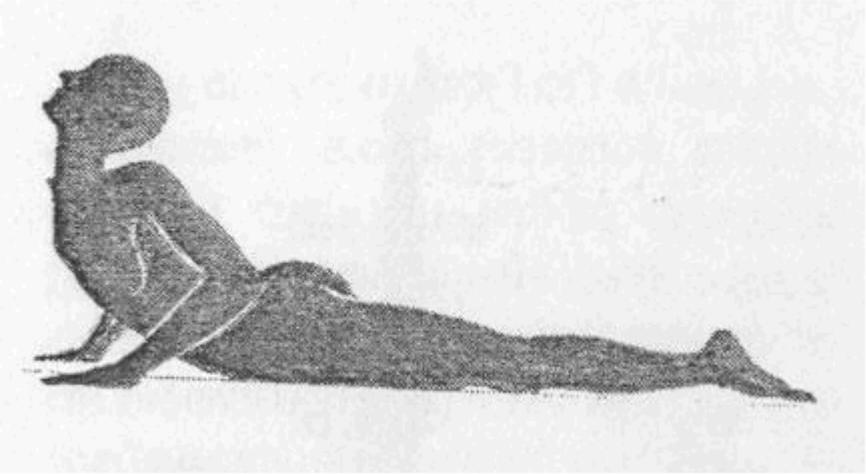
Lie on stomach stretching the entire body ... hands close to body ... palms upward, tuck below your thighs. Rest your head on chin. Straighten your head so as to bring your gaze parallel to the floor. Slowly raise both the legs together without bending the knees and keeping the toes stretched back. Remain in this final position for a while and bring down the legs slowly. When the legs are raised all other parts of the body should be relaxed.



Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

7. BHUJANGASANAM

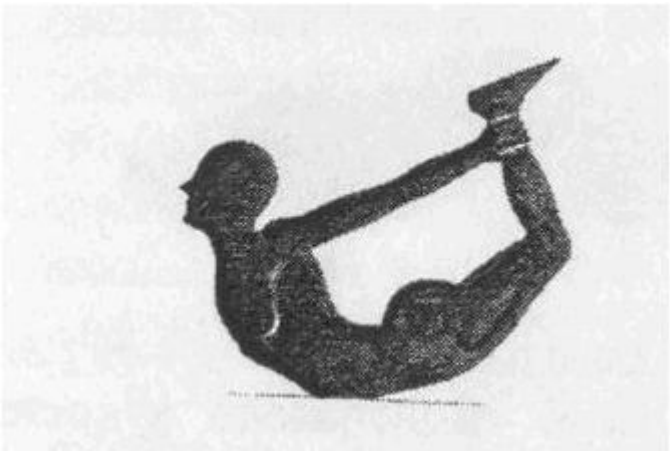
Lie on your stomach. Fold your hands and place the palm just in front of the shoulders ... arms close to body. Keep your forehead on the floor and bent the head backward and slowly raise the head and spine upwards *without exerting force on the hands.* Keep your legs relaxed (do not keep them raised on the toes). Remain in this final posture for some time and come down to earlier stage by bringing down the spine and head and bent down the head until it toches the floor. Unfold the hands.



Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

8. DHANURASANAM

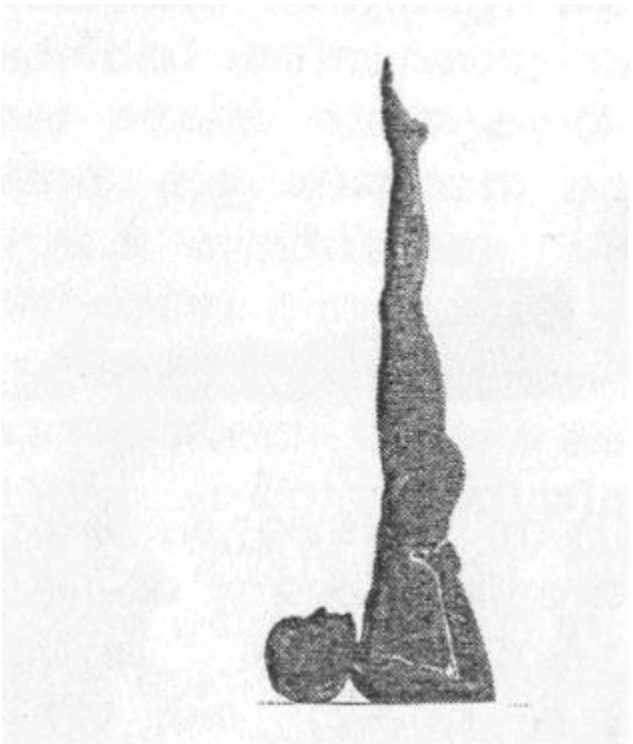
Lie on stomach. Fold your legs and hold them by hands just below the heads. Slowly pull the legs backward (do not pull by hands) so as to raise the leg region and the head region simultaneously of the same height and the hands remain parallel to the ground. Remain in the final position for a few seconds and come back to earlier position.



Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

9. SARVANGASANAM

Lie on safine position. Slowly raise your legs and buttock and bring the legs behind the head (as in poorna halasan) and slowly raise it upwards and remain on the back of the head neck, shoulder too and hands keeping the knees and toes stretched upard at 90^{o}. Support your body with hands holding at the sides of the abdomen. Remain in this final posture for a while and back to earlier position by unfolding the hands and keeping it on floor fold the legs ... bring it behind your head ... then slowly come down and rest the back, buttock and then the legs on the floor.



Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

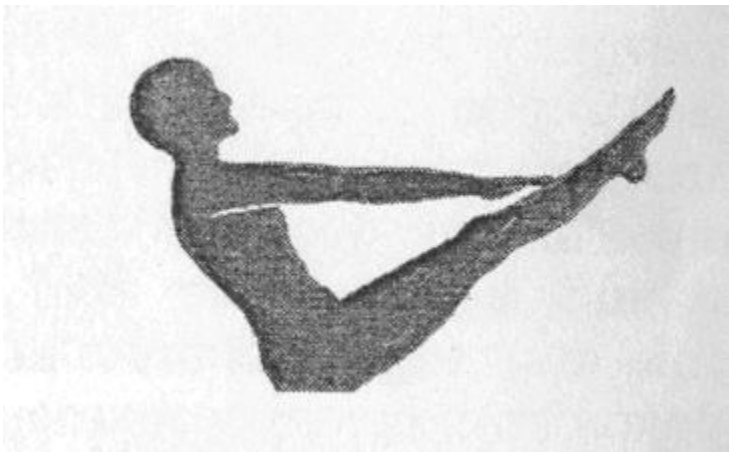
10. MALSYASANAM

Sit in padmasan – that is keep your right leg on the left thigh (close to naval region) and the left leg on the right thigh. Then slowly lie down supporting your body on each ankles one after another. Raise your hands upwards and bring them behind your shoulders ... keep the palm on floor (fingers towards the shoulders). Supporting on the hands raise the chest part and bend the head backward and rest the head on head-top. Bring forward the hands and rest it on thighs and ankles on floor.

Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

11. NAUKASANAM

Lie on your back stretched, legs together hands close to body and head straight. Slowly raise your legs without bending the knees and keeping the toes stretched forward and simultaneously raise the spine area keeping the head straight and stretch the hands forward. Keep the hands parallel to the floor. Now body rests on buttock alone remain in that final posture for a few seconds and come back to earlier lying position.

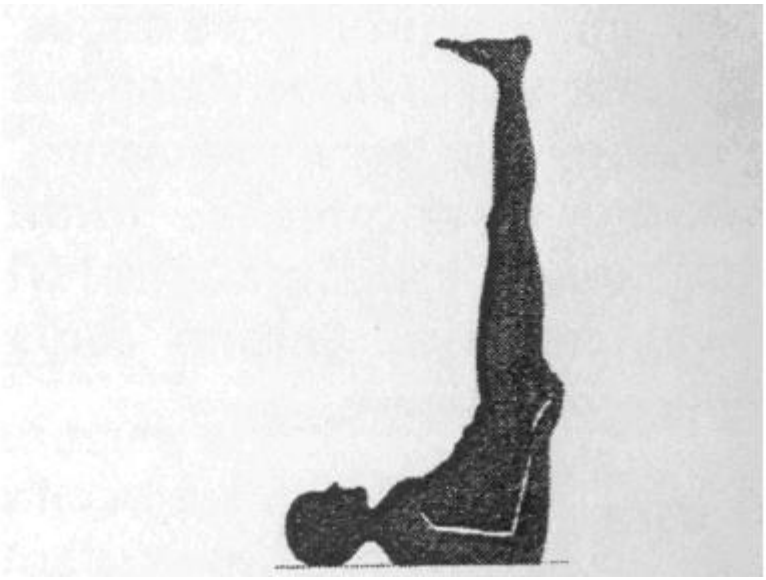


Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

12. VIPARITHA KARANI

Lie on your back stretched. Legs together, hands close to body palm downward. Bring your legs back to your head as in Poornahalasana and lift your legs and buttock upward without bending the knees and not stretching the toes. Support your buttock with the hands. Keep the legs at 90^{o} upwards and remain in this final posture for a while and then come back to earlier position by folding the legs and bringing them

back at your head ... keep your hands on the floor ... bring down buttock and then the legs to the floor.



Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

13. BHADRASANAM

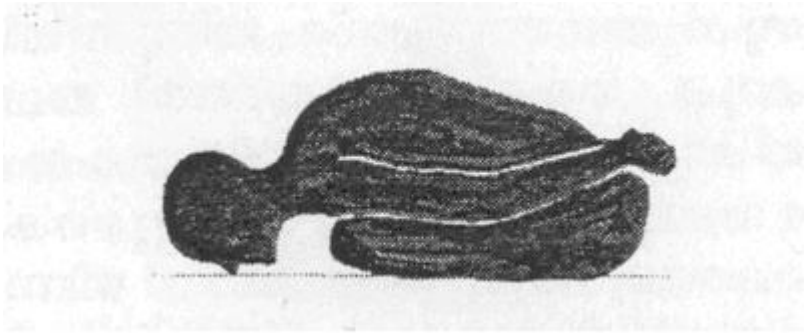
Sit on the floor. Keep your legs facing its bottoms each other and hold them by your hands locking the fingers. Now sit errect, pull the heels towards your anal area and bring down the thighs towards the floor. Remain in this final posture and come back to earlier position.

Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

14. YOGAMUDRA - 1

(in Padmasanam)

Sit in Padmasana – that is – keep your right leg over the left thigh and the left leg over the right thigh ... sit straight ... spine errect. Bring lyour hands behind and hold the right ancle with the left hand and the left ancle with theright hand tightly. Then slowly bent forward lso as to touch the forehead on the floor. Remain in this final posture for a few seconds and come back to earlier position. Do only as much you can. Do not struggle to touch forehead on floor if you cannot.



Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

15. YOGAMUDRA - 2

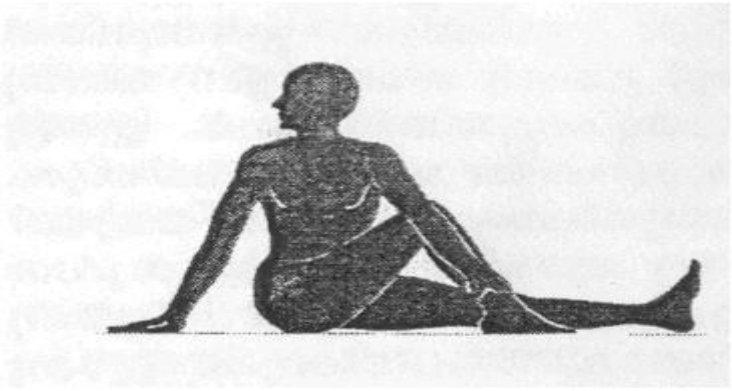
(In Vajrasanam)

Sit on legs. The right buttock on the right leg and the left buttock on the left leg.The big toes should touch each other while the right heel should be bent towards the right and the left heal towards the left so as to contain the buttocks comfortably on. Now fold your hands to make fists and place the right fist at the right bottom side of the abdomen and the left fist at the left bottom side of the abdomen. Now slowly bent forward and touch the forehead on the floor. Keep the ancles close to body without raising the buttock from the heel. Remain in the final posture for some time and come back.

Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

16. VAKRASANAM

Sit streaching both the legs forward. Fold the right leg and place the right heel adjacent to the left knee. Lift the right hand bring it back and place it on the floor behind (right hand fingers directing toward back). Raise your left hand up and bring it upward the right knee and clutch the right leg at its ankle. Now bring the spine errect and slowly turn your head through the right side towards back upto 180 degrees. Feel the twisting of each vertebral column. Remain in that final posture for a while and come back very slowly, bringing back the head to earlier position.



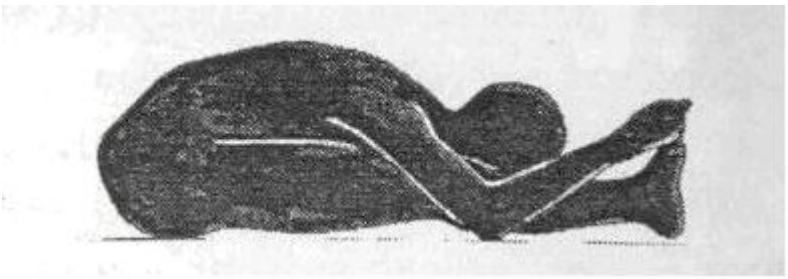
Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

17. ARDHA MALSENDRASANAM

Sit stretching both the legs forward. Fold the right leg and bring it beneath the left thigh. Bend the left leg and place the left foot at the right side of the right leg. Fold the left hand and keep it across the back touching the dorsal palm tight at the left side. Bring the right hand up and move it towards right down and hold the left leg just above the feet. Now turn the head towards left and look back the head turning upto 180^{o}. Remain in this final posture for some time and then come back to earlier state of sitting with legs stretched forward. Bend the left leg and bring it beneath the right thigh. Fold the right leg and place the right foot at the left side of the left leg. Fold the right hand and keep it across the back touching the dorsal palm tight at the right side. Bring the left hand up and move it towards left down and hold the right leg just above the feet. Now turn the head towards right and look back turning the head upto 180^{o}. Remain in this final posture for some time and then come back to the earlier position.

18. PACHIMOTHAMASANAM

Sit stretching the legs forward. Raise your hands and bent forward until your forehead touches the knees. Hold your toes with both hands touching the ankles on the floor. Remain in the final posture for a few seconds and then come back to earlier position.



Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

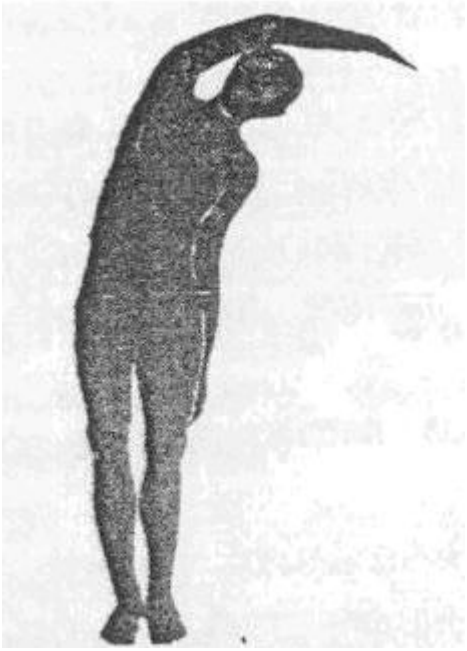
19. VRIKSHASANAM

Remain standing legs close. Lift your right leg and hold it and pull the heel upward so as the heal should touch the anal region. Sole touching right at the left ventral thigh. Remain in the left leg properly balancing the body raise your hands up and join the palms above your head and bring the hands down at the middle of the chest. Slowly close the eyes and balance the body. Remain in that final posture for a while and come back to the initial standing position.

Repeat the same procedure for the left leg also. Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

20. ARDHAKADI CHAKRASANAM

Remain standing, legs close. Hands close to body, head straight and spine errect. Slowly lift your right hand up to 90^o, turn the palm upward and raise it further until the arm touches your right ear and still further applying force with the hand turn the head and spine towards left while the left hand is gliding down tightly through the left side. Remain in this final posture for a while and slowly bring back the right hand ... at 90^o turn the palm downward and then bring down the right hand. Similarly lift the left hand ... turn the palm up at 90^o ... touch the left arm at the left of your head. Turn the head and spine towards right with the force of the left hand while the right hand is tightly gliding down the right side. Remain in this final posture for a while and come back to earlier position by bringing back the left hand ... at 90^o turn the left palm downward and bring down.



Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

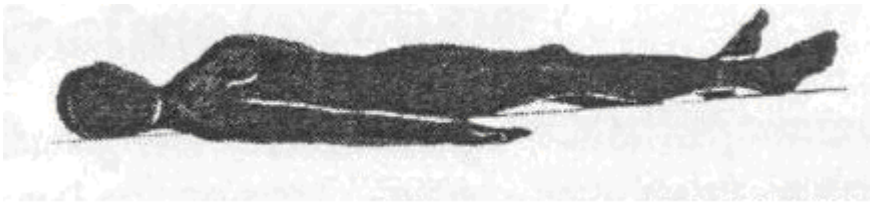
21. SAVASANAM

Lie in supine ... legs apart ... hands apart palms up ... turn your head to left or right ... slowly close the eyes. Relax your body completely ... no tension anywhere in the body ... deep breathing – without making noise ... slow and steady breathing ...

Now bring your awareness to the particular body parts I announce and relax that part (without any movement at that part) with more awareness.

Now bring your awareness to your heels ... relax the heels ... relax the upper part of the feet ... bring your awareness to the knees ... relax them ... relax your thighs ... Be aware of your buttock area ... relax that area.

Relax your abdominal area .. be aware of the chest area and relax that area. Now bring your awareness to your hands ... relax the fingers ... the forearm and the upper arm ... be aware of the shoulders ... relax them ... loosen your neck ... relax your neck ... bring your awareness to your cheeks ... relax your cheeks ... relax your glotis ... and the tongue ... do not hold the teeth clenched, relax them ... relax the lips ... be aware of the nose area ... relax ... loosen your eyelids ... relax them ... relax the eyebrows ... relax your forehead.



Now your entire body is completely relaxed ... no tension anywhere in your body ... deep breathing ... you be aware of the complete relaxation of your body ... deep breathing. Relax further and further as I count from one to ten ... one ... two ... three ...

more and more relaxation ... four ... five ... six ... more and more relaxation ... seven ... eight ... nine ... more and more relaxation ... ten .... Now your body is completely relaxed ... deep breathing ... slow and steady long breaths ... be aware of the breathing ... pay attention to air coming in your lungs and air going out of your lungs ... feel the air coming in and going out. Remain in this complete relaxation for 5 minutes in silence ... decide not to fall asleep. Observe your breathing for 5 minutes in silence. (After 5 minutes) ... Now slowly ... very slowly open your eyes and sit in Padmasanam and continue the observation of breathing ... the zen meditation ... we did at the beginning.

22. VAJRASANAM

Sit on legs. Keep the knees close The right buttock on the right leg and the left buttock on the left leg. The big toes should touch each other while the right heal should be bent towards the right and the left heel towards the left so as to contain the buttocks comfortably on. Spine errect and place your hands on the knees stretched. Remain in that final position for some time and then come back.

Breathing slow and steady without much noise as per your requirements. Relax in Savasanam.

23. PADMASANAM

Sit cross legged. Keep your right leg over your left thigh and the left leg over the right thigh. Spine errect. Stretch your hands and keep them on your knees – ventral side upward. Make a circle touching the tip of the index finger and the thump of each hand.

CONTINUE MEDITATION FOR TWO OR THREE MINUTES. PAY ATTENTION TO BREATHING.

FEEL THE AIR COMING INTO YOUR LUNGS AND GOING OUT OF YOUR LUNGS. SLOW DEEP AND STEADY BREATHING.

HAVE A PLEASANT FACE (not to smile).

NOW CHANT OMKAR (OR ANY OTHER MANTHRA OF YOUR PREFERENCE LIKE 'ALLAH' OR 'HALELUYYA') THREE TIMES

Chant together when I say 'Start'.

Take a deep breath …..... start …..... OM ….....

Take a deep breath …..... start …..... OM ….....

Take a deep breath …..... Start …..... OM ….....

Now slowly open your eyes.

Now it is time for you to ask doubts about any aspects of Yogasanam.

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Note: This Yogasana course was designed by Sri. Sreenivasan, a close associate of Jiddu Krishnamoorthi. This self-help manual was presented in a workshop at a national seminar of clinical psychologists at Ayodhya and the same is published in the Journal of Community Psychology (Baby, J., 2004). The manual is based on the experiential insights derived from training programme for about two decades held in the Calicut University Psychology Department in association with the National Service Scheme activities.