ALCOHOLISM

getting the facts

U.S. Department of Health and Human Services
National Institutes of Health
National Institute on Alcohol Abuse and Alcoholism

ALCOHOLISM
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For many people, the facts about alcoholism are not clear. What is alcoholism, exactly? How does it differ from alcohol abuse? When should a person seek help for a problem related to his or her drinking? The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has prepared this booklet to help individuals and families answer these and other common questions about alcohol problems. The following information explains both alcoholism and alcohol abuse, the symptoms of each, when and where to seek help, treatment choices, and additional helpful resources.

A Widespread Problem

For most people who drink, alcohol is a pleasant accompaniment to social activities. Moderate alcohol use—up to two drinks per day for men and one drink per day for women and older people—is not harmful for most adults. (A standard drink is one 12-ounce bottle or can of either beer or wine cooler, one 5-ounce glass of wine, or 1.5 ounces of 80-proof distilled spirits.) Nonetheless, a large number of people get into serious

trouble because of their drinking. Currently, nearly 17.6 million adult Americans abuse alcohol or are alcoholic. Several million more adults engage in risky drinking that could lead to alcohol problems. These patterns include binge drinking and heavy drinking on a regular basis. In addition, 53 percent of men and women in the United States report that one or more of their close relatives have a drinking problem.

The consequences of alcohol misuse are serious—in many cases, life threatening. Heavy drinking can increase the risk for certain cancers, especially those of the liver, esophagus, throat, and larynx (voice box). Heavy drinking can also cause liver cirrhosis, immune system problems, brain damage, and harm to the fetus during pregnancy. In addition, drinking increases the risk of death from automobile crashes as well as recreational and on-the-job injuries. Furthermore, both homicides and suicides are more likely to be committed by persons who have been drinking. In purely economic terms, alcohol-related problems cost society approximately $185 billion per year. In human terms, the costs cannot be calculated.

What Is Alcoholism?

Alcoholism, also known as "alcohol dependence," is a disease that includes four symptoms:

- **Craving:** A strong need, or compulsion, to drink.
- **Loss of control:** The inability to limit one's drinking on any given occasion.

- **Physical dependence:** Withdrawal symptoms, such as nausea, sweating, shakiness, and anxiety, occur when alcohol use is stopped after a period of heavy drinking.
- **Tolerance:** The need to drink greater amounts of alcohol in order to "get high."

People who are not alcoholic sometimes do not understand why an alcoholic can't just "use a little willpower" to stop drinking. However, alcoholism has little to do with willpower. Alcoholics are in the grip of a powerful "craving," or uncontrollable need, for alcohol that overrides their ability to stop drinking. This need can be as strong as the need for food or water.

Although some people are able to recover from alcoholism without help, the majority of alcoholics need assistance. With treatment and support, many individuals are able to stop drinking and rebuild their lives.

Many people wonder why some individuals can use alcohol without problems but others cannot. One important reason has to do with genetics. Scientists have found that having an alcoholic family member makes it more likely that if you choose to drink you too may develop alcoholism. Genes, however, are not the whole story. In fact, scientists now believe that certain factors in a person's environment influence whether a person with a genetic risk for alcoholism ever develops the disease. A person's risk for developing alcoholism can increase based on the person's environment, including where and how he or she lives; family, friends, and culture; peer pressure; and even how easy it is to get alcohol.

What Is Alcohol Abuse?

Alcohol abuse differs from alcoholism in that it does not include an extremely strong craving for alcohol, loss of control over drinking, or physical dependence. Alcohol abuse is defined as a pattern of drinking that results in one or more of the following situations within a 12-month period:

- Failure to fulfill major work, school, or home responsibilities;
- Drinking in situations that are physically dangerous, such as while driving a car or operating machinery;
- Having recurring alcohol-related legal problems, such as being arrested for driving under the influence of alcohol or for physically hurting someone while drunk; and
- Continued drinking despite having ongoing relationship problems that are caused or worsened by the drinking.

Although alcohol abuse is basically different from alcoholism, many effects of alcohol abuse are also experienced by alcoholics.

What Are the Signs of a Problem?

How can you tell whether you may have a drinking problem? Answering the following four questions can help you find out:

- Have you ever felt you should cut down on your drinking?

- Have people annoyed you by criticizing your drinking?
- Have you ever felt bad or guilty about your drinking?
- Have you ever had a drink first thing in the morning (as an "eye opener") to steady your nerves or get rid of a hangover?

One "yes" answer suggests a possible alcohol problem. If you answered "yes" to more than one question, it is highly likely that a problem exists. In either case, it is important that you see your doctor or other health care provider right away to discuss your answers to these questions. He or she can help you determine whether you have a drinking problem and, if so, recommend the best course of action.

Even if you answered "no" to all of the above questions, if you encounter drinking-related problems with your job, relationships, health, or the law, you should seek professional help. The effects of alcohol abuse can be extremely serious—even fatal—both to you and to others.

The Decision To Get Help

Accepting the fact that help is needed for an alcohol problem may not be easy. But keep in mind that the sooner you get help, the better are your chances for a successful recovery.

Any concerns you may have about discussing drinking-related problems with your health care provider may stem from common misconceptions about alcoholism and alcoholic people. In our society, the myth prevails that an alcohol problem is a sign of moral weakness.

As a result, you may feel that to seek help is to admit some type of shameful defect in yourself. In fact, alcoholism is a disease that is no more a sign of weakness than is asthma. Moreover, taking steps to identify a possible drinking problem has an enormous payoff—a chance for a healthier, more rewarding life.

When you visit your health care provider, he or she will ask you a number of questions about your alcohol use to determine whether you are having problems related to your drinking. Try to answer these questions as fully and honestly as you can. You also will be given a physical examination. If your health care provider concludes that you may be dependent on alcohol, he or she may recommend that you see a specialist in treating alcoholism. You should be involved in any referral decisions and have all treatment choices explained to you.

Getting Well

Alcoholism Treatment

The type of treatment you receive depends on the severity of your alcoholism and the resources that are available in your community. Treatment may include detoxification (the process of safely getting alcohol out of your system); taking doctor-prescribed medications, such as disulfiram (Antabuse®), naltrexone (ReVia™), or acamprosate (Campral®) to help prevent a return (or relapse) to drinking once drinking has stopped; and individual and/or group counseling. There are promising types of counseling that teach alcoholics to identify situations and feelings that trigger the urge to drink and to find new ways to cope that do not

include alcohol use. These treatments are often provided on an outpatient basis.

Because the support of family members is important to the recovery process, many programs also offer brief marital counseling and family therapy as part of the treatment process. Programs may also link individuals with vital community resources, such as legal assistance, job training, childcare, and parenting classes.

Alcoholics Anonymous

Virtually all alcoholism treatment programs also include Alcoholics Anonymous (AA) meetings. AA describes itself as a "worldwide fellowship of men and women who help each other to stay sober." Although AA is generally recognized as an effective mutual help program for recovering alcoholics, not everyone responds to AA's style or message, and other recovery approaches are available. Even people who are helped by AA usually find that AA works best in combination with other forms of treatment, including counseling and medical care.

Can Alcoholism Be Cured?

Although alcoholism can be treated, a cure is not yet available. In other words, even if an alcoholic has been sober for a long time and has regained health, he or she remains susceptible to relapse and must continue to avoid all alcoholic beverages. "Cutting down" on drinking doesn't work; cutting out alcohol is necessary for a successful recovery.

However, even individuals who are determined to stay sober may suffer one or several "slips," or relapses, before achieving long-term sobriety. Relapses are very

common and do not mean that a person has failed or cannot recover from alcoholism. Keep in mind, too, that every day that a recovering alcoholic has stayed sober prior to a relapse is extremely valuable time, both to the individual and to his or her family. If a relapse occurs, it is very important to try to stop drinking once again and to get whatever additional support you need to abstain from drinking.

Help for Alcohol Abuse

If your health care provider determines that you are not alcohol dependent but are nonetheless involved in a pattern of alcohol abuse, he or she can help you to:

- Examine the benefits of stopping an unhealthy drinking pattern.
- Set a drinking goal for yourself. Some people choose to abstain from alcohol. Others prefer to limit the amount they drink.
- Examine the situations that trigger your unhealthy drinking patterns, and develop new ways of handling those situations so that you can maintain your drinking goal.

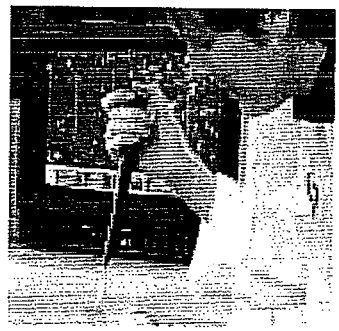
Some individuals who have stopped drinking after experiencing alcohol-related problems choose to attend AA meetings for information and support, even though they have not been diagnosed as alcoholic.

New Directions

With NIAAA's support, scientists at medical centers and universities throughout the country are studying alcoholism. The goal of this research is to develop better

ways of treating and preventing alcohol problems. Today, NIAAA funds approximately 90 percent of all alcoholism research in the United States. Some of the more exciting investigations focus on the causes, consequences, treatment, and prevention of alcoholism:

- **Genetics:** Alcoholism is a complex disease. Therefore, there are likely to be many genes involved in increasing a person's risk for alcoholism. Scientists are searching for these genes, and have found areas on chromosomes where they are probably located. Powerful new techniques may permit researchers to identify and measure the specific contribution of each gene to the complex behaviors associated with heavy drinking. This research will provide the basis for new medications to treat alcohol-related problems.
- **Treatment:** NIAAA-supported researchers have made considerable progress in evaluating commonly used therapies and in developing new types of therapies to treat alcohol-related problems. One large-scale study sponsored by NIAAA found that each of three commonly used behavioral treatments for alcohol abuse and alcoholism—motivation enhancement therapy, cognitive-behavioral therapy, and 12-step facilitation therapy—significantly reduced drinking in the year following treatment. This study also found that approximately one-third of the study participants who were followed up either were still abstinent or were drinking without serious problems 3 years after the study ended. Other therapies that have been evaluated and found effective in reducing alcohol problems include brief intervention for alcohol abusers (individuals who



are not dependent on alcohol) and behavioral marital therapy for married alcohol-dependent individuals.

- **Medications development:** NIAAA has made developing medications to treat alcoholism a high priority. We believe that a range of new medications will be developed based on the results of genetic and neuroscience research. In fact, neuroscience research has already led to studies of one medication—naltrexone (ReVia™)—as an anticraving medication. NIAAA-supported researchers found that this drug, in combination with behavioral therapy, was effective in treating alcoholism. Naltrexone, which targets the brain's reward circuits, is the first medication approved to help maintain sobriety after detoxification from alcohol since the approval of disulfiram (Antabuse®) in 1949. Acamprosate, an anticraving medication, has been widely used in Europe and just recently was approved for use in the United States. Researchers believe that acamprosate works on different brain circuits to ease the physical discomfort that occurs when an alcoholic stops drinking. All of these new medications have their roots in neuroscience research, as do other drugs that are currently under investigation for the treatment of alcoholism.
- **Combined medications/behavioral therapies:** NIAAA-supported researchers have found that available medications work best with behavioral therapy. Thus, NIAAA has initiated a large-scale clinical trial to determine which of the currently available medications and which behavioral therapies work best together. Naltrexone and acamprosate will each be tested separately with different behavioral

therapies. These medications will also be used together to determine if there is some interaction between the two that makes the combination more effective than the use of either one alone.

In addition to these efforts, NIAAA is sponsoring promising research in other vital areas, such as fetal alcohol syndrome, alcohol's effects on the brain and other organs, aspects of drinkers' environments that may contribute to alcohol abuse and alcoholism, strategies to reduce alcohol-related problems, and new treatment techniques. Together, these investigations will help prevent alcohol problems; identify alcohol abuse and alcoholism at earlier stages; and make available new, more effective treatment approaches for individuals and families.

Resources

For more information on alcohol abuse and alcoholism, contact the following organizations:

Al-Anon Family Group Headquarters, Inc.
1600 Corporate Landing Parkway
Virginia Beach, VA 23454–5617
Phone: (757) 563–1600; Fax: (757) 563–1655
Email: WSO@al-anon.org
Internet address: http://www.al-anon.alateen.org

Makes referrals to local Al-Anon groups, which are support groups for spouses and other significant adults in an alcoholic person's life. Also makes referrals to Alateen groups, which offer support to children of alcoholics. Free informational materials and locations of Al-Anon or Alateen meetings worldwide can be obtained by calling the toll-free number (888) 425–2666 from the United States or Canada, Monday through Friday, 8 a.m.–6 p.m. (e.s.t.).

Alcoholics Anonymous (AA) World Services, Inc.
475 Riverside Drive, 11th Floor
New York, NY 10115
Phone: (212) 870–3400; Fax: (212) 870–3003
Email: via AA's Web site
Internet address: http://www.aa.org

Makes referrals to local AA groups and provides informational materials on the AA program. Many cities and towns also have a local AA office listed in the telephone book. *All communication should be directed to AA's mailing address: AA World Services, Inc., Grand Central Station, P.O. Box 459, New York, NY 10163.*

National Council on Alcoholism and Drug Dependence, Inc. (NCADD)
22 Cortlandt Street, Suite 801
New York, NY 10007
Phone: (212) 269–7797; Fax: (212) 269–7510
Email: national@ncadd.org
HOPE LINE: (800) NCA–CALL
(24-hour Affiliate referral)
Internet address: http://www.ncadd.org

Offers educational materials and information on alcoholism. Provides phone numbers of local NCADD Affiliates (who can provide information on local treatment resources) via the above toll-free, 24-hour HOPE LINE.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
5635 Fishers Lane, MSC 9304
Bethesda, MD 20892–9304
Phone: (301) 443–3860; Fax: (301) 480–1726
Email: niaaaweb-r@exchange.nih.gov
Internet address: http://www.niaaa.nih.gov

Makes available free informational materials on all aspects of alcoholism, including the effects of drinking during pregnancy, alcohol use and the elderly, and help for cutting down on drinking.

Update ON HUMAN BEHAVIOR

Vol. 7 No. 2

from the office of...

THOMAS J. HANNIE, JR., PH.D.

Please don't skip reading this issue of the UPDATE newsletter thinking that it's irrelevant because you aren't an alcoholic.

You may not be, but someone you know *is* — your spouse, a relative, a friend, the neighbor across the street, a co-worker, perhaps even your boss. One out of every seven Americans is an alcoholic and for every *identified* alcoholic, there are 5 more who remain unidentified.

Alcoholism touches everyone's life. It is the #1 health problem in this country, and the third leading cause of death. Yet 35 out of 36 alcoholics never receive any treatment. **It is our most untreated treatable disease.**

This issue of the UPDATE defines the alcoholic personality and explains what alcoholism is; how it affects families and children; the cost of alcoholism to American business; and how to get help.

IN THIS ISSUE . . .

I Can Quit Any Time:

ALCOHOLISM IN AMERICA

Who's Alcoholic? The stereotyped picture of the alcoholic as a drunken, skid-row bum is a myth. **95% of all alcoholics are employed.** 45% of them hold management positions; 50% have college degrees.

Alcoholism may be defined as a disease, an addiction, or dependency, but the symptoms are the same:

- an overwhelming desire to drink
- ever-increasing tolerance for alcohol
- personality changes caused by drinking
- impaired judgment due to drinking
- concealed drinking
- emotional and/or physical isolation from friends and family
- difficulty in daily functioning
- physical problems
- blackouts from drinking

The alcoholic drinks compulsively to the point of intoxication, over and over again, and continues to do so despite the concern of family and friends, physicians' warnings and that little voice inside that says, **"You're killing yourself."**

How It Develops **Alcoholism is a chronic, progressive disease, just** like Alzheimer's or diabetes. It begins with the discovery that drinking can produce a temporary mild euphoria, and progresses to *looking forward* to that feeling and then to seeking it out. The need becomes an obsession, which becomes an addiction.

Social drinking leads to psychological addiction for the alcoholic, and at some point, the body's metabolic processes are altered to include and depend upon alcohol. This is where physical dependence — true addiction — begins.

Alcoholic Personality **Alcoholism may be caused** by an inherited vulnerability to alcohol or may be passed from parent to child as a *learned* way of coping with discomfort and stress.

In either case, these traits characterize addiction personalities:

- anxiety about personal relationships
- emotional immaturity
- excessive dependency
- tendency to be smokers and/or heavy coffee drinkers
- low tolerance for frustration
- feelings of loneliness & isolation
- low self-confidence & self-esteem
- impulsiveness
- perfectionism
- ambivalence towards authority
- inability to express emotions
- excessive guilt

Denial is the chief symptom of alcoholism. **"I can quit any time"** is a typical statement. This is not the same as lying — it is self-deception. a defense against unpleasant realities. The alcoholic may be the only one who believes his denial, but his is often so vehement that friends and families remain silent. ●

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Alcoholism & The Family

Alcoholism is a family disease. Living with an alcoholic means constant stress, anxiety, and uncertainty for everyone in the family.

Families develop various strategies for coping with the alcoholic:

- **Denial:** Everyone in the family denies that anything is wrong, yet no one feels right.
- **Adaptation:** Making excuses for alcoholic behavior, lying to cover the drinking, becoming absorbed in other activities.
- **Verbal Strategies** such as lectures, threats, pleas of self-respect, or promises.
- **Behavioral Strategies** such as hiding or refusing to buy alcohol, marking bottles, avoiding the alcoholic, or staying away from home.
- **Disengagement:** withdrawing socially from friends and community activities and emotional withdrawal characterized by emotional numbness.

28.6 million children have alcoholic parents. They live in a state of constant tension and anxiety. Each day, they worry about whether their parents will be drunk or sober. They feel trapped in a hopeless situation, rarely bring friends home, and usually have no one to talk to about the chaos at home. 80%-90% of teenage suicides are related to alcoholism in the family.

Children receive conflicting messages from an alcoholic parent: Leave me alone/I need you; I love you/Go away. As a result, the primary trait of children of alcoholics is low self-esteem.

Children of alcoholics are 4 to 5 times more likely to become alcoholics than children of non-alcoholic parents. They are also more likely to marry an alcoholic, even though they rarely know about the condition going into the marriage. ●

Adult Children

The impact of an alcoholic parent continues to be felt in adult life. The most prevalent feature of Adult Children of Alcoholics (ACOAs) is their confusion about what constitutes "normal behavior." They know that their family wasn't typical but they don't know what "normal" is.

Adult Children of Alcoholics are characterized by —

- difficulty completing projects
- habitual lying
- harsh self-judgments
- being irresponsible or overly responsible
- taking themselves very seriously
- difficulty with intimate relationships
- excessive need for control
- impulsive behavior without thinking about the consequences
- constant need for approval
- feeling "different" from others
- extreme loyalty, even when undeserved ●

Employee Assistance Programs Work

Alcoholism In The Workplace

American industry has a multi-billion dollar hangover. Estimates of the annual cost to business of alcohol-related problems on the job range from $25 billion to as much as $100 billion a year. 60% of all substandard job performance is alcohol-related and the cost of lost productivity alone has been estimated at $31.65 billion a year.

An alcoholic employee costs his company 25% of his salary in lost productivity, absenteeism, medical costs, poor performance, and industrial accidents, as well as the additional supervisory time required by erratic, uneven performance and attendance. When employees' alcohol problems are identified and treated, these costs go down and production goes up. Cost savings from reduced absenteeism alone are estimated at $1,000 per employee treated.

Alcoholics value their jobs more than anything else, including their health or even their families, so job performance is usually the last area to be affected by their drinking. Although often the last to realize that a problem exists, employers are frequently the first and most effective in seeking a constructive solution. Employers recognize that it is more cost effective to treat an alcoholic employee than to replace him. They recognize that alcoholism is a disease and are becoming increasingly active in offering treatment options for employees with drinking problems.

Many companies have **Employee Assistance Programs** which provide counseling and referral services for substance abuse and emotional problems. These are very effective in treating alcohol abuse: 6 to 8 of every 10 referred patients return to their jobs with successful long term recoveries. For every dollar invested in EAPs, employers realize returns ranging from $2 to $20. ●

Alcoholism Kills

Alcohol & Your Health

Alcoholism kills 100,000 to 200,000 Americans a year. There are 13 million alcoholics: 34 out of 35 of them will die from their drinking either directly or indirectly.

Consider the following:

- Alcohol abuse is second only to Alzheimer's disease in causing mental deterioration in adults.
- Fetal Alcohol Syndrome is the 3rd leading cause of birth defects.
- Alcoholics are 10 times as likely to die from fires as non-alcoholics, and 5 to 13 times as likely to die from falls.
- Alcoholics commit suicide 6 to 15 times more often than the general population.
- Alcoholism is a factor in —
  40% of all suicide attempts
  67% of homicides
  54% of all violent crimes
  80% of domestic violence
  60% of emergency room admissions
  40% of industrial accidents
  50% of all traffic accidents
  38%-50% of hospital admission — although most are never so identified ●

Intervention

How You Can Help

The first step in getting help for the alcoholic is *intervention.*

An intervention is a meeting of those close to the alcoholic — family members, employer, close friends — during which they confront him with how his drinking has hurt, embarrassed or angered them. The goal of this confrontation is to force the alcoholic to seek treatment. **It may save his life.**

For an effective intervention —

- Those involved must have real influence over the alcoholic: close family members or an employer.
- The data presented should be *specific, detailed,* and directly related to the alcoholic's drinking.

The alcoholic is out of touch with reality, so intervention should force the realization that the behavior and feelings being described are reality — not the denial that the alcoholic has been using to fool himself.

- Stick to feelings — don't be judgmental. The intention is to show love and concern for the drinker and to use facts about his drinking to legitimize that concern.
- Present available treatment options. Your local mental health professional can help you choose among available community resources for expert, professional treatment.

The assumption that "you can't help an alcoholic until he wants help" is false. **"Treatment or else"** is the strongest motivational factor that exists.

Remember: the goal of intervention is for the alcoholic to accept the need for help, no matter how grudgingly. The recovery rate for alcoholism is exceptionally high and research shows that **alcoholics who are forced into treatment have as good a chance at recovery as those who go willingly.**

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Guidelines

Dealing With An Alcoholic

The first thing that those close to an alcoholic must do is to realize that **you have no control over the alcoholic behavior.** If you want to help, you must first free yourself from the guilt, anxiety and emotional responsibility you've assumed for the alcoholic.

You will not feel strong enough to make an effective intervention until you take back the control you've given the alcoholic over your feelings and your life. Here are some ways to do that:

DON'T	ignore the disease	DO	learn the facts about it: knowledge is power
DON'T	blame the alcoholic	DO	understand your own emotions
DON'T	try to control the alcoholic's drinking	DO	concentrate on the need for treatment & offer options
DON'T	make excuses for the alcoholic	DO	let him suffer the consequences of his actions
DON'T	worry about reasons for the drinking	DO	what you can to make yourself happier
DON'T	make threats	DO	say what you mean & do it
DON'T	extract or accept promises	DO	focus on *actions* — what the alcoholic does or doesn't do
DON'T	seek advice from the uninformed	DO	seek out professional sources of information such as AA
DON'T	blame yourself — you're not the cause of the drinking	DO	get help for yourself
DON'T	hide the fact that you're seeking help	DO	tell the alcoholic what you're doing
DON'T	nag, preach, or lecture	DO	let the alcoholic know you still love *him* but don't approve of his *actions* ●

Treating Alcoholism

Most treatment methods are based on the concept that **alcoholism is a disease** — physical, psychological, or both. The goal of treatment is to break the alcoholic's dependency on alcohol, and to remove the compulsive need to drink. All treatment programs strive to restore adequate strength for the person to cope with life without the help of alcohol. The earlier treatment is obtained, the greater the chances for recovery.

Short-term services to help *break the alcohol habit* include: detoxification, physical & psychological evaluation, and brief (10 days to 2 weeks) intensive hospital treatment programs that use individual, group, and family therapy as well as alcoholism counseling and education.

Long-term services to *control addiction* may include psychotherapy, medical care, drug therapy and self-help/support groups such as Alcoholics Anonymous. Alcoholism treatment experts agree that AA is essential in maintaining sobriety. AA now includes Al-Anon groups for spouses & adult family members of alcoholics; Alateen for children 11-21 yrs old; Alatot for younger children; and ACOA (Adult Children of Alcoholics) groups.

Other sources of help include the National Council on Alcoholism (733 Third Ave., NY 10017) which sponsors Alcohol Information Centers in cities and the Nat'l. Clearinghouse for Alcohol Info. (Box 2345, Rockville, MD 20852). ●

UPDATE ON HUMAN BEHAVIOR

Sex Differences

Women & Alcohol

There are more than **2 million female alcoholics** and their numbers are increasing faster than male alcoholics. Alcoholism usually starts later in life for women, but *progresses much more quickly.*

Women are more susceptible than men to alcohol because they have less water in their bodies to dilute it. Female alcoholics are more likely to drink alone, to hide their drinking, and to feel guilty and ashamed about it. They suffer more depression from drinking, and are more likely to develop other chemical dependencies such as prescription drugs. They are more likely to develop serious complications from alcoholism.

9 out of 10 wives stay with alcoholic husbands, but only 1 in 10 husbands stays with an alcoholic wife. ●

Is This You?

Are You An Alcoholic?

Are you an alcoholic? Alcoholics always know deep down that something is wrong, but the denial that is part of the disease prevents them from seeing that alcohol is the root of their problems.

If you have experienced 3 or more of the following, the chances are high that you are or are becoming alcoholic:

1. Absence or lateness at work due to drinking.
2. Conflict or unhappiness at home due to drinking.
3. Drinking to overcome shyness or build self-confidence.
4. Needing increasing amounts of alcohol to relax and "let down".
5. Regrets about drinking.
6. Financial difficulties due to drinking.
7. Pushing drinks on others; discomfort with those not drinking.
8. Carelessness about family's welfare when drinking.
9. Decreased ambition since drinking.
10. Drinking in the morning.
11. Difficulty sleeping due to drinking.
12. Poor job performance or job in jeopardy due to drinking.
13. Drinking to escape worries or troubles.
14. Drinking alone.
15. Loss of memory as a result of drinking.
16. Resentment of those who want you to stop drinking. ●

PROFESSIONAL PROFILE

THOMAS J. HANNIE, JR., PH.D.

Thomas J. Hannie, Jr., Ph.D., is a Clinical Psychologist, who has practiced in Metairie since 1973. His areas of practice include:

- individual psychotherapy and behavior therapy
- pain evaluation/management, including back pain, headache, and TMJ
- psychosomatic illness
- marital & sex therapy
- child and family assessment, therapy, and behavior management
- forensic psychology
- stress management
- career development

He uses short-term behavioral therapy techniques to help individuals become independent and self-sufficient.

Dr. Hannie sees patients on a consulting basis at several area hospitals, including East Jefferson General Hospitals, Doctor's Hospital of Jefferson, and Lakeside Hospital. He is a Vice-President of the Psychological Service Center of New Orleans, Inc., an industrial psychology consulting firm, where he evaluates employees and helps people adapt to their working environments.

He received his Ph.D. in Clinical Psychology from the University of Georgia, where he minored in Industrial/Organizational Psychology and Sociology with a sub-specialty in Behavior Therapy. His M.S. in Psychology is also from the Univ. of Georgia, and his B.S. in Psychology from Louisiana State University.

He has served as a psychological consultant to the Jefferson and St. Charles Parish school systems, as well as to the Jefferson Parish Juvenile Court. Dr. Hannie's professional experiences include staff positions at Charity Hospital and Metairie Mental Health Center. He has testified in district, state, & federal courts as an expert witness on issues involving personal injury, employment potential, child custody, and other areas. He has addressed committees of the Louisiana State Legislature and the U.S. Congress on numerous mental health topics.

His seminars include **Stress Management, Child Management,** and **Behavioral Medicine.** He has appeared as a guest on several local radio and television programs and has published research on the nature of hypnosis and the treatment of anxiety and depression.

Dr. Hannie has been Chairman of the Louisiana State Board of Examiners of Psychologists; President of the Louisiana Psychological Assoc.; and President of the Orleans Society of Applied Psychologists. He is licensed and /or certified in both Louisiana and Texas; is listed in the National Register of Health Service Providers in Psychology; has Diplomate status with the Amer. Board of Vocational Experts; and is a Certified School Psychologist.

His professional memberships include the American Psychological Assoc.; American Psychology-Law Society; Behavior Therapy & Research Society; Assoc. for the Advancement of Behavior Therapy; Southeastern Psychological Association; New Orleans Behavior Therapy Society; Southeastern Assoc. for Behavior Therapy; Assoc. for the Advancement of Psychology; and the Psi Chi Honorary Society in Psychology

Drinking a 6-pack . . . of beer increases a teen-ager's chances of dying in a car crackup by 100-fold: U. of Rochester public policy analyst, Charles Phelps. Why aren't more "drunk drivers" being treated for alcoholism? Page 6.

The Better Way

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What alcohol does to your body

In America today, getting together with friends is usually a time for serving drinks. Celebrating? Raise your glass. Depressed? Drown your sorrows. Lonely? Tired? Tense? Relax, have a drink. Hardly anyone thinks twice about it.

Maybe you should. Even in moderate amounts alcohol has noticeable effects on the body. Because it enters the bloodstream it touches almost every organ, and its effects on feelings and behavior are well known. And when you drink heavily over a prolonged time, alcohol can cause a number of serious diseases, some of them fatal. Certain physical effects of alcohol result from its direct toxicity; others occur because alcohol alters the metabolic process or the enzyme systems within certain cells. Here, from the comprehensive new *Book of Health*, are the ways in which alcohol can affect your body:

The central nervous system

Sustained heavy drinking damages the brain and practically all parts of the nervous system.

Brain damage accelerates the aging process and impairs mental function, resulting in faulty judgment, marked instability in mood, difficulty in concentrating, forgetfulness, and a "scatterbrained" state.

Peripheral neuropathy involves a degeneration of peripheral nerves that produces sensory changes. Pain may be produced by light stroking of the skin, whereas sticking the person with a sharp object such as a needle causes little reaction. Other symptoms include weakness and pain that are most pronounced in the legs and arms.

Wernicke syndrome and Korsakoff's psychosis usually occur together. The former is characterized by global confusion (not knowing where one is or the people around one or what time it is), paralysis of the eye muscles, causing double vision, and peripheral neuritis. The B vitamins, especially thiamine, reverse some symptoms of Wernicke syndrome in a few days. However, the patient is left with some degree of Korsakoff's psychosis, a condition characterized by short-term memory gaps.

Other rare conditions associated with alcohol-induced nutritional deficiencies are:

Alcoholic cerebellar degeneration, which affects balance, gait, and coordination.

Central pontine myelinolysis and **Marchiafava-Bignami's disease** cause the protective covering of brain cells to be destroyed.

Alcoholic amblyopia causes impairment of vision, but is reversible in time with large doses of vitamin B_{12}.

The digestive system

Since alcohol is swallowed and ultimately metabolized primarily in the liver, the organs of the digestive tract show many of its harmful effects.

Liver. The liver is the great chemical factory of the body. Within it, food, alcohol, and other drugs are transformed into products ready for assimilation and elimination. The metabolism of the vast quantity of alcohol in an alcoholic's liver puts a great burden on its chemical resources and results directly in the pronounced liver damage that characterizes alcoholics. Three main reactions that frequently occur in progression as liver damage is increased are:

Fatty liver, in which globules of fat displace the material of individual liver cells, is the initial change. The liver becomes enlarged, shiny, and greasy. Fatty liver disappears when alcoholic intake is stopped.

Hepatitis, or inflammation of the liver, is a second response. This can be very severe and painful, with resulting enlargement of the liver, jaundice, weakness and lethargy, fever, decrease or loss of appetite, and finally death. There is no specific medication that can help it. Alcoholic hepatitis may subside with good nursing care and the discontinuation of drinking, although some degree of cirrhosis may remain.

Cirrhosis of the liver, the laying down of scar tissue, is the inevitable result of inflammation. The scar tissue replaces healthy cells, causing de-

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What alcohol does to your body *continued*

creased liver function. Symptoms of cirrhosis include jaundice, fluid retention, and bodily wasting. The liver structure is deformed, which dams up the blood at its entrance and further decreases its function. The increased pressure may lead to internal hemorrhage, anemia, and poor blood clotting. Death can result from any one or a combination of these conditions.

Although not all cases of cirrhosis are alcohol-related and not all alcoholics develop the disease, about 85 percent of deaths due to cirrhosis are associated with alcohol. Damage to the liver due to cirrhosis is irreversible, but the outlook can be improved with abstinence and a nutritious diet supplemented with multivitamins.

Pancreas. This organ is extremely important in the digestive processes, for it produces the enzymes that help digest meats, carbohydrates, and proteins; the pancreas also produces insulin. Excessive use of alcohol may result in *pancreatitis*—the inflammation of the pancreas and disturbance of its functioning.

In its mildest form, pancreatitis may be dismissed as transient gastritis. However, it can also present itself as an acute emergency involving intense abdominal pain, a rapid pulse rate, and a drop in blood pressure similar to the abdominal crisis arising from a ruptured ulcer or appendix.

The patient with chronic pancreatitis becomes thin and malnourished. Stools become bulky and odorous. When enough pancreatic tissue is destroyed, the production of insulin is reduced and diabetes develops.

Mouth. Chronic alcoholism is associated with *gingivitis* (swelling and bleeding gums) and other dental problems. Alcohol also affects the salivary glands by increasing stickiness of the saliva, causing blockage of the salivary duct and a mumpslike appearance due to swelling of the parotid gland.

Stomach. Gastric hemorrhage from erosive gastritis is frequently observed in alcoholic patients, particularly those who also take aspirin routinely. Peptic ulcers have also been associated with drinking, and alcohol is known to slow healing of ulcers.

Cardiovascular diseases

Chronic consumption of alcoholic beverages in large doses damages the heart and cardiovascular system.

Heart attack. Current evidence suggests that moderate drinkers—one or two drinks a day—have a high risk of dying from a heart attack. Some studies show that moderate drinkers—one or two a day—are less likely to suffer a heart attack than either abstainers or heavy drinkers. However, not enough is known about this effect in moderate drinkers to justify the intake of alcohol to protect against a heart attack.

Heart damage. Once a person has suffered a heart attack, alcohol in doses over five drinks a day decreases one's life expectancy.

Heartbeat irregularities (arrhythmias). Heavy drinkers have an increased frequency of heartbeat irregularities that can lead to death. In a large study, where over 95 percent of the sudden deaths were due to arrhythmias, 30 percent occurred among heavy drinkers, although they made up only 10 percent of the total sample studied. However, other factors such as cigarette smoking also affect the rate of sudden death.

Beriberi heart. Alcoholics often become malnourished because heavy drinking reduces appetite. One type of malnutrition seen in alcoholics is lack of thiamine (vitamin B_1), which can lead to beriberi, a disease well known in Asia. Beriberi is rare in the U.S. today because thiamine is added to many food products.

Cardiomyopathy. In some chronic alcoholics, heart disease is due to a toxic effect on the heart muscle resulting from the laying down of scar tissue between the small fibers of the heart muscle, making it less flexible. This condition responds only to prolonged medication accompanied by abstinence from alcohol.

High blood pressure. There is evidence that use of substantial amounts of alcohol increases blood pressure. Even in nonintoxicating doses, alcohol results in an immediate, albeit slight, rise in blood pressure.

Cancer

There is no doubt that heavy consumption of alcohol significantly increases the risk of cancers of the mouth, esophagus, pharynx, and larynx, principally, if not exclusively, among those who smoke or chew tobacco. Whether alcohol increases the risk for these cancers in the absence of tobacco usage is not known.

Those who drink hard liquor (Scotch, whiskey, vodka, gin, etc.) in heavy quantities run an increased risk of cancer of the oral cavity (except although there is no evidence that the social drinker who consumes one or two drinks a day has an increased risk. When beverages with lower alcoholic content such as wine and beer are drunk in great excess, some increased risk is also found. The risk of cancer is the same whether the liquor is drunk straight or diluted. Thus the amount of alcohol, rather than the type of beverage, is significant.

Liver cancer is also related to alcohol. Cirrhotics have a greatly increased frequency of liver cancer, although the relation between alcohol and liver cancer is unclear.

Fetal alcohol syndrome

Birth defects found in the children of women who drink unusually heavily during pregnancy are collectively called the Fetal Alcohol Syndrome (FAS). FAS affects approximately two infants per 1,000 births; it includes mental deficiency, facial abnormalities, birthmarks, and defects of the heart, lungs, joints, and sexual organs. The cessation of drinking as late as the second trimester of pregnancy decreases the defects. Women are advised to drink very lightly or not at all during pregnancy.

Overweight

When alcohol is metabolized, it provides almost twice as many calories as sugar or starch. Consumed in modest amounts, it may stimulate the appetite, too, thus causing overweight.

Other effects

Alcoholism is associated with many types of *anemia*, or decreases in the amount of red blood cells, causing fatigue and poor health. Most anemias of alcoholics are reversed just by stopping drinking. Other effects on the blood include interference with the scavenger action of white blood cells against invading bacteria and with chemical agents in the blood related to the immune system that help fight infection. All these make infections more frequent and harder to overcome for the alcoholic.

Alcohol can make the bones weaker and thus predisposed to fractures.

Atrophy of the testicles is a direct result of alcohol consumption and a side effect of cirrhosis of the liver.

Drug interactions. The combination of alcohol with other drugs is dangerous.

From THE BOOK OF HEALTH by the American Health Foundation, edited by [illegible]

FAMILY CIRCLE BOOK BONUS:

HOW TO STOP THE ONE YOU

Like most alcoholics, my husband and I lived the big lie: We swore that we didn't have a drinking problem, and we blamed our personal troubles on each other, not on booze. Luckily, the people who loved us got us to seek help—before it was too late.

I remember the day of my last drink. I'd come to work all dressed up. I had decided to play the great boss and take everyone out for lunch. At 11:30 A.M. I went into my sales manager's office and told him to put on his coat. Fifteen minutes later, the two of us and five other people who worked at Mary Ellen Enterprises were seated in a nearby restaurant.

My drinking started slowly. It usually did. I ordered a glass of wine instead of my usual scotch, because I'd been putting on weight. Besides, I intended to go back to work.

The minute I took a sip, I knew I wouldn't stop. Lunch dragged on. The others went back to the office. I stayed in the restaurant, drinking, until about 5 o'clock.

When I drove home, no one was there. The details of the early evening are still foggy. I know I continued to drink, but I wanted some companions. I called around, and since no one answered, I decided to visit an aunt and uncle who lived about 15 miles away. I knew they'd have liquor. Somehow, I drove there.

I don't remember anything more of that evening. I awoke Saturday morning in my aunt's house, dying of thirst and full of guilt about the events of the night before. On top of that, I remembered that my 9-year-old son, Andrew, and husband, Sherm, were leaving on a trip to Florida that morning.

I drove home, praying they hadn't yet left, so I could say goodbye. Their luggage was in the hall. I had planned to drive them to the airport, but in my absence Sherm had been forced to make other arrangements. My parting words to him were, "I'm so sorry. Something is very wrong with me. I don't think I'll be home when you get back."

I crawled into bed, threw the covers over my head and spent the day there, trying to block out memories of the day and night before. I drifted in and out of troubled sleep.

Early Sunday morning, I was desperate to talk to someone. I called my friend and business associate, Ann, who agreed to meet me at a local diner.

Photo by Thomas S. England

1979: Although my husband and I tried to be good parents to our son, Andrew, our drinking often got in the way.

Best-selling author Mary Ellen Pinkham, America's most famous household-hints expert, writes a regular column for FAMILY CIRCLE.

start telephoning. This is still drinking alone. It is also a nice way of making a fool out of yourself.

5. Does he or she lose time from work because of drinking?

As the disease progresses, an alcoholic employee may go out for lunch and not return. He or she may start coming to work with a hangover, be excessively tardy (especially on Monday mornings) and often call in sick.

6. Does he or she appear remorseful after drinking?

On the day following a drinking binge, I'd be extra nice to my husband. I'd take the day off and ask him to go somewhere with me, maybe to a show. Eventually, the only time we did anything together was when I was feeling remorseful. Sherm began to look forward to the times when I was in this state. Those were times when I needed him, when I wasn't as self-sufficient and as busy as usual. This is how the disease can take over the family.

7. Has he or she forgotten what happened while drinking?

"I drink to forget," say some alcoholics. And for many, it's a frightening fact: They experience alcoholic blackouts that can last for days.

Before I entered treatment, I was having blackouts almost every time I drank. I wouldn't forget the whole day, just bits and pieces of it.

8. Has he or she missed planned family or social activities because of drinking?

I have never before admitted this to anyone: I missed my father-in-law's wake because I was home in bed with a hangover. I loved Sherm's dad, but I was so sick that day I couldn't go.

9. Does drinking make him or her careless of the family welfare?

Most alcoholics think they're pretty good parents. I did—until I dug deep inside myself and realized I was a hypocrite. I would lecture Andrew about not using drugs, then I'd drink and drive.

Other alcoholic parents ruin their kids with kindness. In my drinking days, I'd buy Andrew anything he

INTERVENTION MAY BE THE SOLUTION

You can ask the alcoholic to stop. You can *beg* him or her to stop. I have some very important news for you: An alcoholic doesn't *want* to stop drinking. Out of every 10 alcoholics, 9 will drink themselves to death unless someone or something *intervenes* with the drinking.

You can help—with "intervention," an orchestrated process in which the family, friends and perhaps the employer of the alcoholic express their feelings. Trained counselors talk to you beforehand, educating you about alcoholism as a disease and preparing you for what might happen during the intervention session.

If you want to stop someone you love from drinking, you must first find a counselor. I suggest that you set up an appointment with a counselor trained in alcoholism treatment who has had experience with the Intervention process. You can also write to: Families in Crisis, 6101 Green Valley Dr., Bloomington, MN 55437; or telephone (612) 893-1883.

The counselor will help you determine if the Intervention method is possible, will suggest the names of other concerned friends or family who may want to be included and ask that everyone get together before confronting the alcoholic. When you all meet, the counselor will help each of you recall and write down information to put in "letters," or statements, to be read out loud to the alcoholic; these statements explain your feelings about how the disease has particularly affected you.

The objective is to make the alcoholic agree to have a professional evaluation or enter into treatment.

GETTING TREATMENT

I chose inpatient treatment at Hazelden. There I discovered that I often covered up my feelings by joking. I discovered that I was very angry at my husband, because he was an alcoholic was able to take responsibility for the way the rest of my life was going to take shape.

When I left Hazelden, I didn't want to make any immediate changes in my life. On the way home, my brother and I discussed how difficult it would be for me to live with Sherm, who was still drinking.

I carried my suitcase into the house and the first thing I saw way my husband stretched out on the couch. He was looking very haggard, very ill. It occurred to me that while I'd been away, he'd had free rein to drink.

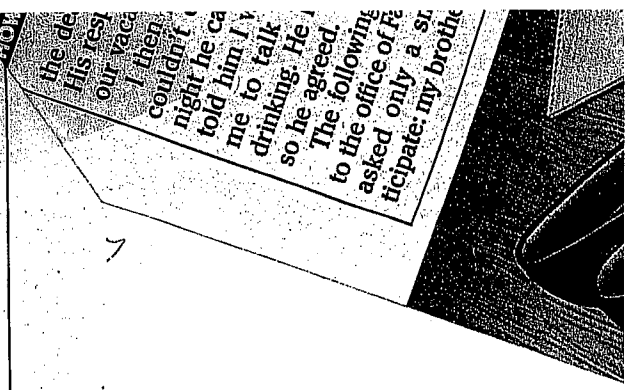
"Sherm," I said, "I really am going to stay sober. I'm going to work at this program, and I'm not fooling around. It's going to involve a lot of changes in my life, and it's difficult for me to be in a marriage while you're drinking."

He denied that he had a problem. "I never did drink like you, Mary Ellen," he said, and that was the truth. He didn't binge. Sherm drank to be "normal." He drank every day, but rarely to the point of complete intoxication. Like most alcoholics, he was quite convincing. He promised, "If I get into any trouble—if I get blotto or intoxicated—I'll get help."

Over the next few months, Sherm did a good job of hiding his drinking. Then one day he met some friends for lunch. Afterward, he came home totally intoxicated. His car zigzagged down the block. He was so drunk that he could barely steer it into the driveway.

The next morning I told him, "You made your choice last night. Six months ago, you said that if you got intoxicated, you'd get help. So here's

(Please turn to page 18)



the deal: Either get out, or get help." His response was to take off alone for our vacation cabin in the north.

I then phoned Families in Crisis. I couldn't delay any longer. On the night he came back from the cabin, I told him I wanted him to come with me to talk to someone about his drinking. He knew I meant business, so he agreed.

The following afternoon, we drove to the office of Families in Crisis. I had asked only a small group to participate: my brother, two good friends of Sherm's and our son, Andrew. I was the first to speak. I reminded Sherm that when he came into my life, I had seen him as a knight in shining armor, a handsome guy with a great job who made me proud to be with him. As the years went by, he started seeing a lot of job disappointments related to his drinking. Eventually, he'd lost his ambition and, along with it, his identity. He was no longer the strong man I'd once admired.

His friends talked about how they'd known about his drinking on the job and how they'd felt obliged to defend him, but that they had to face the facts. My brother, Johnny, recalled bad times at the lake when he'd seen Sherm sitting on the porch, sloshed.

Andrew said, "Remember when we went out with my friend Pat and you kept saying, 'I'll just have one more drink, and then we'll go home?' You kept having just one more, Dad, and when we finally left, Pat and I were very frightened. You were swerving. And then Pat went home and told his family, and he wasn't allowed to play with me anymore." (I never suspected Sherm was driving while intoxicated with kids in the car, nor would Andrew have felt free to tell me.)

The Intervention session didn't take much more than 10 minutes. Sherm finally said, "O.K., what do I do now?" We went home afterward with the understanding that he would check into a treatment center the next day—just seven months after I had sobered up.

I didn't have any more fears about whether I had made the right choice. Intervening on Sherm wasn't only my right, it was my obligation. And if you want to stop the one you love, it's yours as well.

My husband became ill on January 1 of this year, just as I was finishing the first draft of this book. On January 26 he went into the hospital, where he was diagnosed as having terminal cancer of the lungs. He died at home on February 23.

By caring for ourselves, we wound up caring for each other. Instead of seeing a person who had been the source of a lot of my trouble, I started seeing in Sherm the man I had always loved, a man of gentle spirit, the man he was meant to be had he not had this awful disease. I was so grateful that when my husband died, I loved him. I don't have any doubt in my mind about that.

What a great gift it was for Sherm to die sober. His scores had been settled. He was at peace with his family, his friends, his God. You come into life sober, and you ought to leave it sober.

I have tried to be completely honest. I hope you can be honest, too. Don't live a lie. Don't turn away from the facts that alcoholism and other chemical dependencies are serious and that you and the one you love need help. Get *help*—and you'll know what living is really meant to be. ■

Ties That Blind Codependency

Do you constantly seek approval, fear criticism, overextend yourself, and give the needs of another person such a high priority that you are unaware of your own? If so, you may be codependent.

Codependent people often appear to others as capable, healthy, self-sufficient, and in control of their lives, while in reality, they feel insecure and afraid, self-doubting and in need of assurance.

photo by JOHN GEISTER

Dr. Jerry Harber, a marriage and family counselor in Memphis, Tenn., works regularly with clients who exhibit codependent characteristics. "Until recently, we only used the term 'codependent' to describe those persons participating in a relationship with an alcoholic or drug abuser. Today, experts in the field are discovering similar codependent behaviors in families and/or relationships where there is no alcohol or drug addiction."

Any number of circumstances can foster codependency. Some of the most common are: overdependence, compulsive or addictive behavior, serious physical or mental illness, rigid moral or religious beliefs, sexual abuse, and child abuse. "In response to these and other situations," says Dr. Harber, "codependents tend to over-develop in one or more areas. Some need to be caretakers or controllers. They may be super achievers and super responsible. Others despair of ever getting the attention they crave. They feel rejected, frustrated, and inadequate. Instead of realizing that other family members or a mate is troubled, they tend to blame themselves. Their self-esteem can be very low. Sadly, a troubled family or mate unknowingly encourages these feelings. Without intervention, codependents continue this cycle and go on to form other codependent relationships."

The Koala Center in West Memphis, Ark., not only treats the alcoholic and drug abuser, but the codependent person as well. The center defines codependency by the following:

- My good feelings about who I am stem from being liked by you.
- My good feelings about who I am stem from receiving approval from you.
- Your struggle affects my serenity. My mental attention focuses on solving your problems or relieving your pain.
- My mental attention is focused on pleasing you, protecting you, and manipulating you (to do it my way).
- My own hobbies and interests are put aside. My time is spent sharing your interests and hobbies.
- Your personal appearance and behavior are dictated by my desires, as I feel you are a reflection on me.
- I am not aware of how I feel; I am aware of how you feel.
- I am not aware of what I want; I ask what you want.
- I am not aware; I assume.
- The dreams I have for my future are linked to you.
- My fear of rejection and fear of your anger determines what I say or do.
- I use giving as a way of feeling safe in a relationship.
- My social circle diminishes as I involve myself with you.
- I put my values aside in order to connect with you.
- I value your opinion and way of doing things more than my own.
- The quality of my life is in relation to the quality of yours.

Dr. Claudia Black, an international expert on codependency and the national adviser for the Koala Center, calls codependency a "compulsion to seek a sense of 'worthwhileness outside of one's self.'" It is characterized by an exaggerated sense of responsibility for another person to the exclusion

Codependency can be conquered, but it does not go away by itself.

of self-caring. Codependents many times are not able to identify or express their feelings. They find it difficult to "let go" and spontaneously enjoy good times. Because they suffer from a general sense of failure and low self-esteem, they frequently set impossible expectations for themselves and others, and must constantly receive approval from others in order to feel worthwhile. Codependents tend to see things in either black or white with very few choices in between. They are afraid of being lonely, and therefore would rather be in a bad relationship than no relationship at all.

No matter what problems exist in these relationships, and whatever type of individuals are involved, codependency is a habitual system of thinking, feeling, and behaving toward one's self and others. While codependents frequently react to people who are destroying themselves, they end up destroying their own lives. This habitual behavior leads persons into, or keeps them in, destructive relationships that eventually don't work.

It is perfectly natural for us to care about others, to want to protect and contribute to their happiness. What makes codependents different is in the way they let other people's behavior affect them and in the ways they try to affect others: "the controlling, the caretaking, extreme dependency on other people, obsessions with others that result in the abandonment of self, low self-worth, and the ongoing process of living for and through others."

"Being codependent does not mean that a person is bad, inferior, or even mentally ill," cautions Dr. Harber. "Many individuals learned these behaviors as children. Plenty of women were taught these characteristics were feminine, attractive attributes, and especially were encouraged to live out that role. Others have developed these behaviors for survival in a complicated situation. However, the very behaviors designed for survival can be self- destructive, and the codependent's world becomes out of control."

More than anything, codependent persons struggle to maintain control over their lives, but continue to feel powerless to make meaningful changes. One client of Dr. Harber's finally realized that something was very wrong in her life, and sought counseling. "She described herself as trapped and alone. She had no one to turn to, to confide in. She spent all her time caring for and looking after everyone else, and when she needed something, no one was there to help. She was seen as 'good, old dependable Sue,' there when you need her. She desperately wanted out, but did not want to lose that feeling of being needed, of being loved."

How do you know if you are experiencing normal emotional distress, or whether you're seriously codependent? Many of the features of codependency resemble normal ups and downs, so it is important to look at the signals such as those outlined above by The Koala Center. To get well means addressing codependency in your life and doing something about destructive behavior patterns. Recognize the course of symptoms operating in yourself and see how the harmful consequences happen in your life. Learn how to intervene by treating yourself with more respect; develop boundaries; own your realities; become responsible for your own wants and needs; and begin to approach life with moderation.

So where do you start? First, consider attending a Twelve-Step meeting where you can be with people who are talking about codependency and recovery from it. Codependents Anonymous (CoDa) is a twelve-step program based on the same steps used by Alcoholics Anonymous. Experts agree this is one of the best ways to overcome codependency.

A second thing you can do for yourself is to get a codependent sponsor. Choose someone who has spent some time in recovery and who demonstrates functional behavior with respect to some codependence symptoms. A good codependent sponsor is someone who can parent and nurture you, who is honest and confrontive, and is able to repeat things over and over until you get them.

Third, confront within yourself each symptom of codependency. Until this is done, you cannot begin to identify the parts of your behavior which need to be changed. It may be helpful to make a list of the behaviors to be addressed and prioritize them so that you have a place to begin.

Fourth, a good counselor is often the key in working through codependency. Make sure you interview the therapist to find out if that person has had experience in this specialized field.

Lastly, a word about nurturing. Codependents must learn to be better caregivers to themselves. Nurturing means loving yourself. It involves finding ways to "hug" yourself, to remind you of your own worth. Discover healthy "gifts" to give yourself. For example, take a bubble bath, exercise,take the phone off the hook and read, plan escapes for quiet time, garden, let the housework go—do whatever feels "great" to you, as long as it's healthy.

Within supportive surroundings such as self-help groups or individual counseling, codependent behaviors can be brought to a balanced place where they can be positive and productive. If you have concerns, take action. Codependency will not go away by itself.

Some good resources are listed below if you want to begin the work of recovery on your own:

photo courtesy of McKAY-DEE HOSPITAL CENTER

To overcome codependency one must evaluate relationships and confront behavior patterns.

The Twelve Steps—A Way Out (Recovery Publications Inc., 1989)

Codependent No More (Melody Beattie)

Facing Codependence (Pia Mellody)

Breaking Free: A Recovery Workbook for Facing Codependence (Pia Mellody and Andrea Wells) ■

BECKY CLENDENIN CAPERTON

KAREN STOLPER

Help That Doesn't Help

Breaking the Codependent Connection

Looking out for yourself is healthy for you, and others too

First Maria stood guard over her alcoholic husband, becoming a recluse in their home in her attempt to stop his drinking. Then, when he blamed his drunkenness on money pressures, she guiltily got a job. The morning after he went on a binge, she quit her promising new career so she could return to sentry duty. "I felt I had to get things under control," she says. "*My* control."

Despite her martyrish efforts to master her husband's behavior, Maria was really controlled by him and his alcoholism, says Melody Beattie, author of "Codependent No More" (Harper/Hazelden, $8.95). Statistics show that Maria is not alone: About 11 million Americans are chemically dependent, and, says Beattie, "their compulsive disorder turns everyone close to them into victims—people who need help."

Often mislabeled as a "tower of strength," the codependent, like Maria, habitually takes on others' problems, worries constantly, gives "help that doesn't help" and, most of all, disregards his or her own well-being. The destructive lifestyle of caretaking, helplessness, anger and self-victimization eventually demolishes the codependent's sense of worth, and can plunge him or her into depression, sometimes even suicide.

"When concern becomes obsession, compassion turns into caretaking and one is looking after others but not oneself, that's codependency," says Beattie.

Stopping codependency involves:

- Recognizing and accepting that you've become overly involved in or affected by another person's troubles.
- Detaching or releasing yourself from that unhealthy entanglement. "Detachment doesn't mean not caring—it means caring without going crazy," says Beattie. "It means understanding that each person is responsible for himself, that he can't solve problems that aren't his and that worrying doesn't help."
- Acting assertively in your own best interest. "Feel your own feelings, live your own life and set your own goals," she says. "There's magic in goals—they make dreams come true."

—Winifred Gallagher

DON'T BE AN "ENABLER"

Information about Rehabilitation Programs

1

For names, addresses, and phone numbers of local 12-Step programs (eg, Alcoholics Anonymous, Narcotics Anonymous, Alanon) and inpatient and outpatient treatment facilities: look in the local telephone book Yellow Pages under "Alcoholism Information & Treatment Centers." Individual programs are also listed in the telephone book white pages.

2

For more information about local programs and a catalog of pamphlets and guidelines, write to:

Alcoholics Anonymous World Services, Inc
PO Box 459
Grand Central Station
New York, New York 10163
(212) 870-3400

3

The Betty Ford Center
39000 Bob Hope Drive
Rancho Mirage, California 92270
(619) 773-4100 or (800) 854-9211

4

For information about physician-oriented support and continuing education, contact the American Society of Addiction Medicine, Inc (ASAM). ASAM is a national medical specialty society of physicians from primary care who treat alcoholics and other drug-dependent individuals. ASAM offers conferences, courses, and a certification examination for physicians and publishes the Journal of Addictive Disorders.

American Society of Addiction Medicine, Inc
5225 Wisconsin Ave, NW
Suite 409
Washington, DC 20015
(202) 244-8948

The CareMedic

INTERVENTION
The Newest Wrinkle in Alcoholism

Paul Ohliger, M.D. *...has been actively involved in the field of alcoholism since 1967. His specialty is internal medicine with a special interest in alcohol and tranquilizer problems.*

At last, carefully staged and directed intervention coupled with loving concern and treatment, can result in cessation of drinking and earlier recovery for alcoholics.

"What really seems to make the difference is to confront the drinker, in a most loving and emphatic manner, with the objective evidence of his or her drinking and the direct results thereof, while at the same time . . . offering direct assistance in following a carefully outlined treatment program"

A great deal of research is going on in the field of alcoholism. Important discoveries may be announced at any moment. Meanwhile, of interest to practicing physicians is the work being done in the area of intervention in the alcoholic's drinking.

For many years it appeared obvious that an alcoholic could not be helped until he "hit bottom" and became willing to seek or accept help. This has been painfully apparent to spouses, relatives, friends, physicians and ministers of practicing alcoholics who have tried to help an alcoholic before he asked for help. "He has to want help" was a common statement.

This picture began to change with the development of Industrial Alcoholism Treatment Programs and the employment of alcoholism counselors in industry. Industry found that it was far more profitable to help their alcoholic employees and executives to recover from alcoholism than it was to discharge and replace them. It was also discovered that threat of loss of job was a severe psychic trauma that could often be used by an alcoholic's employer to force him or her into treatment. "You are a good employee. But you seem to have a problem. Either get treatment or we have to let you go—as of now." Such an approach, combined with hospitalization insurance and the establishment of hospital alcoholism treatment programs, has resulted in the recovery of a great many alcoholics and in their recovery at a much earlier time in the course of their disease than would have occurred otherwise.

The major factor in the success of this approach appears to be the employer's recognition of alcoholism as a disease and his offer of medical treatment. The employee receives State Disability benefits while off work for alcoholism, and is treated as an ill rather than as a misbehaving employee. This is in marked contrast to stating, "I'm warning you for the last time, either shape up or you're fired."

The military services have made the same discovery. It is far more practical to recognize alcoholism as a disease and provide treatment for it than to punish, reprimand, or discharge alcoholic service personnel. This was first discovered by Dr. Joseph Zuska and then Dr. Joseph Pursch at the Long Beach Naval Hospital.

Now the same discovery is being made by practicing physicians and others involved with alcoholics or with the families of alcoholics. That is, it is generally useless, or even worse, to chastise, cajole, threaten, nag or harangue an alcoholic about his or her behavior. If he could change on his own, he would have done so without waiting for someone to suggest it. Likewise, it only shows one's ignorance of the disease for one to tell an alcoholic, "cut down," "don't drink so much," "limit yourself to two drinks before dinner," "stick to beer and light wine," or, even worse, "take these pills and don't drink so much." Neither does it do any good to tell an alcoholic to stop completely, unless you help him find the help that will enable him to do just that. If he were able to do it on his own, he would have already done so and you wouldn't be talking to him about it.

On the other hand, what really seems to make the difference is to confront the drinker, in a most loving and emphatic manner, with the *objective* evidence of his or her drinking and the direct results thereof, while at the same time, again, in a loving manner, offering direct assistance in following a carefully outlined treatment program—all of this coupled with a firm, precise threat of reprisal if treatment is refused.

[Continued on Page 2]

INTERVENTION

(Continued from Page 1)

It works like this: The alcoholic patient very commonly is totally unable to admit that alcohol is a problem. This is not the result of dishonesty so much as the result of the delusional thinking of alcoholism. The delusions result from a combination of (1) chemically-induced blackouts wherein the brain apparently fails to make a "memory tape" as a result of the toxic effect of alcohol upon the brain during that interval of time; (2) psychological blackouts wherein the brain refuses to recall painful events; and (3) what is referred to as "euphoric recall," wherein past painful events are remembered as having been pleasant or at least far less distressing than they were at the time that they happened.

The spouse, relatives, close friends, and perhaps the physician of such a patient meet with an alcoholism intervention specialist for proper coaching and practice. At the appropriate time they meet with the drinker—as a group, never alone—to express their loving concern for his or her welfare and to ask him or her to simply listen until all have spoken. Then each person, in turn, reads his list of past events that he has personally observed, each of which occurred while the subject was drinking. For example:

"You fell down in the bathroom at 2 a.m. last night."

"Last month we had to pay the attorney $900 to get your drunk driving charge reduced to reckless driving."

"Three nights ago you were unable to accept a late night phone call because you had been drinking."

You promised to help me with my homework, but as you continued to drink you kept getting madder and madder."

"You went out for a pack of cigarettes and didn't get back for three hours, and then you were unsteady on your feet, your speech was slurred, and you smelled of alcohol."

"I was embarrassed by your behavior when I brought a school friend home last month and I don't ever want to do that again."

"Your liver function tests are definitely abnormal, your blood pressure is elevated, as is your blood sugar, uric acid, and triglycerides; these are all due to drinking."

"Your speech was slurred over the phone last week."

After each participant finishes his list of evidence, the patient, who up to this point may not have been labeled as an alcoholic except perhaps by the physician, is given specific advice regarding a diagnostic-treatment program. Usually he or she accepts it, if the confrontation has been done in a loving manner, especially if he or she is informed that the alternative is, for example, an immediate divorce or job dismissal. The participants agree that the patient can, if he or she chooses, continue to practice his or her disease. But they insist that he or she will have to do it alone, because they intend to withdraw so that they will not have to continue to witness his or her continued deterioration. On the other hand, should he or she agree to treatment, the family agrees to be involved with the patient in the treatment program in the realization that this is a family disease.

This concept of intervention in alcoholism began with Vernon Johnson, a recovered alcoholic Episcopalian priest who headed the Minneapolis-based Johnson Institute, which trains alcoholism counselors and alcoholism intervention specialists. Such a specialist is Abbot Mills, who is currently located in Palm Desert, California. He is associated with Eisenhower Medical Center and is a consultant for CareManor Alcoholism Hospital in Orange, California, where seminars on intervention for physicians and other interested professionals are being made available.

It is a thrill to see an alcoholic make an abrupt change and a dramatic recovery, especially when you and his or her family have played a significant role in bringing that about. □

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Orange County Medical Association Bulletin *Jan. 1979*

Lead in Table Wines Could Pose Hazards For Pregnant and Nursing Women

FDA is advising health professionals to warn pregnant and nursing women that wine containing even low levels of lead may pose a hazard to the fetus or nursing infant. (Pregnant women should in any case be made aware that alcohol can be dangerous to the developing fetus.)

This warning comes in conjunction with other steps FDA and the Bureau of Alcohol, Tobacco and Firearms (ATF) are taking to reduce consumers' exposure to lead from table wines. ATF is now monitoring the lead content of foreign and domestic table wines. Wines found to contain 300 ppb (parts per billion) or more of lead could be removed from the market.

At the same time, FDA is developing a regulation to ban the use of lead foil capsules that cover the outside rim and cork of some wine bottles. ATF test data show that the lead foil capsules can increase lead levels in wines by leaving lead salt deposits on a bottle's rim that dissolve when the wine is poured.

An ATF study completed in June 1991 showed that only 3% to 4% of the table wines tested contained

Booze Secrecy to Stay

After a five-year court battle, a U.S. Court of Appeals decision has left consumers of beer, wine, and liquor in the dark about what they're drinking. The August decision permits the Bureau of Alcohol, Tobacco and Firearms (BATF) to rescind a 1980 regulation, which had never gone into effect, requiring alcoholic beverage producers to either list ingredients on the label, or provide such information to consumers by mail.

CSPI won two earlier lawsuits requiring BATF to implement the ingredient labeling regulations, but the appellate court found that the Reagan administration's recission of the regulations was technically legal. Dozens of ingredients and additives may be used in alcoholic beverages, and many cause allergic reactions in sensitive people.

Bruce Silverglade, CSPI's legal director, said, "The Food and Drug Administration and American Medical Association agree that manufacturers should list ingredients on beer, wine, and liquor labels. We will continue to press both state and federal agencies for such measures. Ultimately, Congress ought to transfer responsibility for alcoholic beverage labeling from BATF to an agency with more public health expertise, such as the FDA."

With CSPI's lawsuit exerting pressure, industry and government have made some changes. Several brewers now list ingredients on major brands, and some have stopped using additives completely. BATF now requires the labeling of Yellow dye No. 5 and saccharin and will soon require disclosure of sulfiting agents.

Goals and Objectives

Goals

Acceptance

By acceptance, we mean the breakdown of the illusion that the individual, through willpower alone, can effectively and reliably limit or control his/her use of alcohol and/or drugs. Acceptance takes several forms in twelve-step programs:

- acceptance by the patient that s/he suffers from a chronic and progressive illness characterized by compulsive use of alcohol and/or drugs;
- acceptance by the patient that his/her life is (or is becoming) unmanageable as a result of alcohol or drugs;
- acceptance by the patient that s/he has lost the ability to effectively control his/her drinking or using through willpower alone; and
- acceptance by the patient that since there is no effective way to reliably control his/her use, the only viable alternative is complete abstinence from the use of alcohol and drugs.

Surrender

Surrender involves a willingness to reach out beyond oneself and to follow the program laid out in the twelve steps. Surrender includes acknowledgement by the patient:

- that there is hope for recovery—sustained sobriety—only through admitting the reality of his/her loss of control;

- that recovery requires having faith that some Higher Power can help him/her when willpower has been defeated by alcoholism or addiction;
- that fellowships of fellow addicts, such as AA and NA, have helped millions of alcoholics and addicts to sustain their sobriety; and
- that his/her best chances for success are to live the twelve steps and become actively involved in a twelve-step fellowship.

Objectives

These two major program goals are reflected in a series of specific objectives, which are congruent with the AA/NA view of alcoholism and addiction. These specific objectives of recovery are:

Cognitive Objectives

- Patients need to understand some of the ways in which their thinking has been affected by alcoholism and addiction. For example, drinking and using often lead to rationalizing and lying, to one self as much as to others.
- Patients need to understand how their thinking may reflect denial (or "stinking thinking") and how their own rationalizations can contribute to continued drinking or using despite negative consequences. For example, many an alcoholic attributes DWI (driving while intoxicated) arrests to "bad luck"—or bad tires!
- Patients need to see the connection between their substance abuse and the negative consequences that result from it. These consequences may be physical, social, legal, psychological, financial, and spiritual. Many alcoholics and addicts are inclined to resist making causal attributions concerning their drinking or using. For instance, a self-employed cocaine addict may attribute his business failure to a bad economy, unfair competition, or bad employees rather than to his own cocaine-induced mismanagement.

Emotional Objectives

- Patients need to understand the AA/NA view of emotions and how certain emotional states (like anger, resentment, loneliness, and shame) can lead to drinking or using.
- Patients need to be informed about some of the practical ways that AA and NA suggest for dealing with emotions so as to minimize the risks of drinking and using.

Relationship Objectives

- Patients need to understand that alcoholism and addiction constitute "relationships" with mood-altering substances that eventually take precedence over relationships with people, such as friendships, family ties, and intimacies.
- Patients need to see that they systematically encourage the significant others in their lives to "enable" their own alcohol or drug use by helping them obtain alcohol or drugs, and/or by helping them avoid or minimize the negative consequences of their drinking or using.

Behavioral Objectives

- Patients need to understand how their powerful and cunning illness has affected their whole lives, and how many of their existing or old habits support their continued drinking or using.
- Patients need to turn to the fellowship of AA or NA and make use of the resources of those fellowships in order to change their addictive habits.
- Patients need to get active in AA or NA as a means of sustaining their sobriety.

Social Objectives

- Patients need to attend and participate regularly in AA/NA meetings of various kinds, as well as in AA/NA-sponsored social activities.
- Patients need to obtain and develop a relationship with an AA sponsor.
- Patients need to access AA or NA whenever they experience the urge to drink or use, or have had a "slip" (relapse), no matter how minor.
- Patients need to reevaluate their relationships with their "enablers" and with fellow alcoholics and addicts.

Spiritual Objectives

- Patients need to experience hope that they can arrest their alcoholism or addiction.
- Patients need to develop a belief and trust in a power greater than their own willpower.

- Patients need to acknowledge their own character defects, including specific immoral or unethical acts they have committed, and to recognize that they have done harm to others as a result of their alcoholism or addiction.
- Patients need to begin to heal their shame and guilt through sharing their moral inventory with another trusted person.

GROUP PROCESS OF AA

1. Hope is provided by associating with other alcoholics who are not drinking and who apparently are happy, satisfied, or indeed grateful not to be drinking. In other words, change is possible.

2. Universality is formed through sharing stories and experiences involving alcohol. The newcomer is struck by the value of his or her experiences as AA members identify with it and express thanks and gratitude to the newcomer for sharing the story. Instead of feeling condemned, the newcomer feels bonded to these other alcoholics by virtue of his or her experience.

3. Information is provided informally through conversations, through literature published by AA, and through the topics and content of the meetings themselves.

4. Imitation is a very prominent aspect of the group process. Phrases are repeated and rituals are followed.

5. Learning occurs at multiple levels and includes how sober alcoholics view their disease, how they relate to others, and what they do to stay sober. The member also learns that the problem is alcohol (not a spouse, or job, or lack of willpower). It is learned that one has a disease and that alcoholism is cunning, powerful, and baffling.

6. Catharsis can occur. The opportunity is provided (but not demanded) through discussion, speaker, and Step study meetings. Again, one's experiences are appreciated and not subjected to condemnation or judgment.

7. Cohesiveness follows from the ability to identify, usually quickly, with the viewpoints and experiences of fellow members. Cohesiveness is also facilitated by participating in the informal socializing characteristic of AA meetings. One feels at home by helping to make coffee, set up chairs, and eventually greet newcomers.

Symptoms of Alcoholism and Addiction

The primary qualification for a patient's entry into a twelve-step facilitation program is clinical evidence of dependence—the loss of his/her ability to effectively control his/her use of one or more mood-altering substances, including alcohol. In particular, three symptoms in relation to such substances need to be clinically evaluated; tolerance, loss of control, and continued use despite clear negative consequences of that use. All three of these symptoms are discussed in detail in the chapter on Core Topic 1, assessment.

Briefly, patients should be considered candidates for twelve-step facilitation if they manifest all of the following:

- *Tolerance.* The symptom of tolerance develops early in the addiction process. Tolerance refers to the condition in which the mood-altering effects of a substance are habituated with continued use. The drinker or user experiences a diminishing emotional impact or mood swing from the same dose of alcohol or drug over time. As a result, s/he must consume more of a substance, or a more potent form of the substance, or a different substance, in order to achieve the same mood swing. Tolerance therefore appears to drive or motivate increasing alcohol or drug use.
- *Loss of Control.* Loss of control refers to a pattern of progressively ineffective self-control over substance use. The alcoholic or addict cannot reliably predict how much of a substance s/he will use, will not be able to reliably stop once s/he has started drinking or using, and/or will tend to substitute or combine substances in order to stay drunk or high. Loss of control is a cardinal behavioral indicator of addiction. As one alcoholic patient put it, "As an alcoholic, I never wanted one drink. I wanted to get drunk as quickly as I could, and I wanted to stay drunk as long as I could. I might start out with gin, but I'd end up drinking mouthwash if that was all I could get my hands on."
- *Continued Use Despite Negative Consequences.* Chronic substance abuse leads inevitably to progressively severe negative consequences in a variety of critical areas, including the alcoholic's or addict's physical, emotional, social, vocational, and spiritual well-being. Alcoholics and addicts become depressed, alienated, sick, tired, and unreliable. They have accidents and get into fights, lose their jobs, exploit and manipulate others in the interests of continuing their use, and spend money foolishly. Many a marriage has been sacrificed to the alcoholic's or addict's "relationship" with his/her substance(s) of choice. The "insanity" of alcoholism and addiction is the alcoholic's or addict's continued use of the substance in the face of worsening consequences.

Patients who manifest all three of these symptoms should be considered

RELAPSE WARNING SIGNS — COMPOSITE LIST

Reprinted From Staying Sober Workbook

emal Dysfunction.	2. Return of Denial.	3. Avoidance & Defensiveness.	4. Crisis Building.	5. Immobilization.
ulty in — nking Clearly. naging feelings & iotions. nembering things. naging stress. eping restfully. ysical coordination. ame, guilt and pelessness.	◻ Concern of well-being. ◻ Denial of the concern.	◻ Believing "I'll never use again." ◻ Over-involved with others. ◻ Defensiveness. ◻ Compulsive behavior. ◻ Impulsive behavior. ◻ Tendencies toward loneliness.	◻ Tunnel vision. ◻ Minor depression. ◻ Loss of constructive planning. ◻ Plans begin to fail.	◻ Daydreaming & wishfu thinking. ◻ Feelings that nothing can be solved. ◻ Immature wish to be happy.
onfusion & verreaction.	7. Depression.	8. Behavioral Loss of Control.	9. Recognition of Loss of Control.	10. Option Reduction.
eriods of confusion. ritation with friends. Easily angered.	◻ Irregular eating habits. ◻ Lack of desire to take action. ◻ Irregular sleeping habits. ◻ Loss of daily structure. ◻ Periods of deep depression.	◻ Irregular attendance at AA & treatment meetings. ◻ Development of an "I don't care attitude." ◻ Open rejection of help. ◻ Dissatisfaction with life. ◻ Feeling powerless & helpless.	◻ Self-pity. ◻ Thought of controlled use. ◻ Conscious lying. ◻ Complete loss of self-confidence.	◻ Unreasonable resentments. ◻ Discontinues all treatment & AA. ◻ Overwhelming loneli ness, frustration, anger and tension. ◻ Loss of behavioral control.

Return to addictive use or physical/emotional collapse. → ◻ Controlled Use. → ◻ Shame & Guilt. → ◻ Loss of Control. → ◻ Life & health problems. → ◻ Renewed recove or death.

Further Information is available from