TABLE OF CONTENTS

1. Introduction ........................................................................................................................................ 4

2. Objectives of this Manual
3. Tips for the Trainer
4. The methods
   4.1. Lectures
   4.2. Group work
   4.3. Brain storming
   4.4. Case study/scenarios
   4.5. Role playing
5. Duration of the training
6. Monitoring and Evaluation

Day 1 .......................................................................................................................................................... 7

Session 1. Welcome, Introductions, Purpose, and Programme of the training….. 7

Session 2. Alcohol and alcohol abuse ................................................................. 8

Session 3. What is alcohol? .................................................................................. 8

Day 2 .......................................................................................................................................................... 9

Session 4. Review of previous day ........................................................................... 9
Session 5. Why and when people abuse/drink alcohol ........................................... 11
Session 6. Disease concept of alcoholism ............................................................. 13

Day 3 .......................................................................................................................................................... 16
Session 7. Craving, Withdrawals and Detoxification ............................................. 16
Session 8. Alcohol's journey through the body ...................................................... 17

Day 4 .......................................................................................................................................................... 22
Session 9. Alcohol and Your Liver ................................................................. 22
Session 10. Effects and consequences of alcoholism ............................................ 24

Day 5 .......................................................................................................................................................... 28
Session 11. Introduction to 12 steps of Alcoholics Anonymous Recovery Program .... 28

Day 6 .......................................................................................................................................................... 30
Session 12. Denial ........................................................................................................... 30
Day 7 ................................................................. 33
   Session 13. The Addiction Tree ................................. 33

Day 8 ................................................................. 35
   Session 14. Relapse and Triggers ............................. 35

Day 9 ................................................................. 37
   Session 15. Situations that invite relapse ................. 37
   Session 16. Red flags ......................................... 38

Day 10 ............................................................... 40
   Session 17. Heading off a relapse ........................... 40
   Session 18. If you do slip and eventually relapse ...... 41

Day 11 ............................................................... 43
   Session 19. Coodependency .................................. 43

Day 12 ............................................................... 45
   Session 20. Effective management and treatment of codependency .... 45

Day 13 ............................................................... 46
   Session 21. Introduction to Alcoholics Anonymous .... 46

Day 14 ............................................................... 47
   Session 22. Experiential training at National Care centre .... 47

Day 15 ............................................................... 48
   Session 23. Sharing experience of the Experiential training .... 48
   Session 24. Patterns of drinking ............................ 48
   Session 25. Smoking Tobacco and other drugs .......... 48

Day 16 ............................................................... 49
   Session 26. Client motivation and team work ............. 49
   Session 27. The DO's and DON'T'S' Of Online counseling .... 49

Day 17 ............................................................... 50
   Session 28. Way forward ..................................... 50
   Session 29. Evaluation ........................................ 51

Note: Mentoring follows there after..........................
1. Introduction

People have a right to access knowledge on the nature of alcoholism/substance abuse and solutions to the problem. This training manual is designed to provide a guide and improve on the quality of services offered by hotline counselors. Counselors will acquire advanced knowledge in alcohol counselling and be able to support people with alcohol problems who phone in seeking help. The manual will be used by counselors to train others in future.

It is hoped that the trainees for whom this manual has been prepared, will improve in their counseling skills especially in counselling people with alcohol and drug abuse problems.

Counselors will be introduced to the "12 Steps of Alcoholics Anonymous", so that they may use the same principles during their hotline telephone counseling.

Generally, the training will enable hotline counselors to understand better the details of alcohol problems and the recovery program, that they may be able to facilitate change. They will use the acquired knowledge to help alcoholics seeking help, especially those who do not have full access to AA meetings. The affected clients will learn to deal with their feelings and emotions. For example individuals who telephone will be guided to personally admit and accept their problem of alcoholism, carry out self examination and improve their relationships with other people. The trainees will learn to help callers start their own self support groups, such as Alcoholics Anonymous in their communities.

2. The main objectives of this manual are to:

The purpose of this manual is to guide the training of telephone counseling for people with having problems with Alcohol and other drugs. Hotline counselors are being targeted, so that in turn they use the acquired knowledge in counselling people who phone in as well as use it to train others. It is hoped that the trainees for whom this manual has been prepared, will improve in their counseling skills especially in counselling people with alcohol and drug abuse problems.

The manual will guide the facilitator to:

i) Provide on-going training, mentoring and support supervision to the counselors in the area of alcohol and drug abuse.

ii) Give valuable information on the 12 steps program of Alcoholics Anonymous and how it can be used during telephone counseling.

iii) Enable counselors to encourage callers to start AA groups at grassroots communities.

iv) Motivate clients to seek services when referred by the counselors.

3. Tips for the Trainer

The various activities to be performed by the facilitators and participants are elaborately outlined together with the estimated training time for each topic and session. The training model is
participatory in that both the facilitator and participants have ample opportunity to exchange ideas, discuss, and reflect on various issues. Prototype questions are provided to guide the discussions. Separate hand-outs containing brief notes and illustrative materials and examples have been produced to highlight and deepen the understanding of the issues contained in the manual and to aid participants to have after the training reference materials.

4. The methods

The methods of training that have been considered relevant for each session are lectures, group work, brainstorming, case study, story telling, role plays and the use of proverbs where appropriate. This training manual recommends the following:

4.1 Lectures
This is a short talk to introduce, a topic at the beginning, or in the middle or at the end of a training session. The talk will be given by the facilitator to enable the participants gain an insight into the subject matter. For purposes of this manual the lecture methods should be limited to enabling the facilitator either introduce the subject or wrap-up the session presentations.

4.2 Group work
This is the involvement of the trainees in interactive discussions of the subject matter at hand. The participants should be divided into groups of seven to nine participants depending on their number. Each group is presented with task/questions to be discussed. After analyzing the questions each group displays its findings to the plenary using the flip charts or any available means of display. The facilitators with the assistance of all the participants will critic each presentation and contribute to their responses.

4.3 Brainstorming
It is believed that participants have some level of knowledge on the prevailing topic session. They will therefore be involved in a provocative open discussions in the plenary. The facilitator will engage the participants in sessional activity by asking the participants to respond to questions and providing answers that they deem relevant. The responses will be recorded and ranked in a best to worst format. The facilitator wraps up the session with an appropriate lecture to summarize the issues raised in the session.

4.4 Case study/scenario
A case study or a scenario will be presented to the trainees in a written and in comprehensive manner. The trainees will asked to identify the problems or issues in the case, analyze the situation and suggest solutions. These solutions are then compared to the actual solutions that were previously developed in solving such problems.
The participants have to ask relevant questions to secure the additional necessary information about the case or scenario. This sharpens the trainee’s way of asking logical questions, gathering and analyzing the information, synthesizing the information into a structure from where logical conclusions can be made.

4.5 Role Playing
Role playing is a training method which induces people to assume the role of a specific individual under specific conditions. Each role player is also expected to react to the other role playing participants in the group. For example, a trainee may be given the role of a leader who wants to introduce policies on alcohol use in society. He must gather all the data, ask relevant questions to other role playing participants relevant to this situation and offer solutions. Role playing is an excellent method for strengthening interpersonal skills and expands the individual’s understanding of complex inter-related issues.
Role playing helps the participants appreciate other and opposing points of view. For example, where a minister plays the role of a president, he tends to understand what the presidency does better.

5. Duration of the training and sessions
The facilitator shall be guided by the timetable for the different modules, topics and sessions presented at the beginning of each activity. The total estimated time for the training is 15 day and mentoring is 18 days.

6. Monitoring and evaluating the training progress
At every stage the progress of the training will be monitored and evaluated using an appropriate questionnaire or instrument to capture the following questions:

i) Have the participants understood the matters discussed in the various sessions?
ii) Was the training effective?
iii) Was the session organized and managed according to the plan of activity flow?
iv) Did the session meet the needs and expectations the participant?
v) There will also be processing of the learning at the end of each day.
DAY 1

Session 1.0 Welcome, Introductions, Purpose, and Programme of the training.

*Duration: 30 minutes.*

The Facilitator should Welcome the participants and thank them for attending. Introduce yourself and the other facilitator(s) and say something about your background/experience/areas of educational interest. The other facilitator(s) should then do likewise. Let participants also introduce themselves.

Explain clearly the purpose of the workshop, and what it is hoped will be achieved over the next 15 days, i.e. that they will receive a thorough grounding in Alcoholism/Substance abuse approach so that they too will use the acquired knowledge in their telephone counseling. The facilitator will then set some ground rules.

**Expectations and fears**

The facilitator asks participants to mention their expectations and fears. This will enable both the facilitator(s) and the participants achieve their expectations of the workshop. The participants may have certain fears or anxieties at the start of the workshop. These may form a barrier to the learning process unless individuals are allowed to express and discuss them. This will ensure that the whole group is aware of the fears and anxieties of individuals, and will hopefully ensure that these are acknowledged during the tasks set, and by the way in which participants interact with each other.

**Objective of the sessions:**

To offer participants an opportunity to:

- become familiar with the facilitator(s) and the domestic arrangements
- clarify the purpose and details of the workshop programme
- understand the Alcoholism/Substance abuse Initiative
- Help start AA groups in the community

**Setting the ground rules:**

Some common examples of ground rules that may be negotiated on for this workshop include:

- Time keeping
- Listening to and respecting each other
- support for others
- Positive criticism
- Phones in silence or switched off
- others
Session 2.0: Alcohol and Alcohol Abuse [Duration: 1 Hour]

Objectives:
To offer participants an opportunity to:
• Become more familiar with the drug alcohol
• Learn about the 6W's (Who, what, why, when, why and where) of alcohol

Methodology:
Step 1: Lecture: Using a flip chart, Facilitator gives a lecture on "The drug called alcohol", Alcohol History, (40 minutes)

Step 2: Role play: Let participants present a small drama on alcohol brewing in the village and portray how community appreciates its availability (10 minutes)

Step 3: Brainstorming and comment on issues related to Step 1 and 2, using a flip chart (10 minutes)

Session 3.0: What is alcohol? [2 Hours]

Objective:
• To reveal the myth and misconceptions of alcohol use
• To provide a definition of alcohol

Methodology
Step 1. Ask participants to give a definition of alcohol. Brainstorm (30 minutes)

Step 2. Write their answers on a news print
Step 3. Then explain to the participants using a flip chart, the history of alcohol and what is. Tell them that alcohol is a simple chemical, but its effects on the body are extraordinarily complex and highly individual (40 minutes)

Step: Facilitator calls for more Questions from participants (20 minutes)

• Alcohol is known since Stone Age as a beverage, which is: Mood altering, Influencing behavior, causing toxic effects.

Step 5: Evaluate the session activity of the day (30 minutes)

Hand out:

What is alcohol?
When yeast, a microorganism that evolved around two hundred millions years ago, encounters the water and plant sugars in fruits, berries and grains, something very interesting happens. In the process known as fermentation, yeast releases an enzyme that converts the sugars into carbon dioxide (CO2) and ethanol (CH3 CH2 OH, more commonly called alcohol).

A simple one celled organism, yeast doesn’t know when to call it quits and continues to produce alcohol until it expires, the very first victim of acute alcohol poisoning.

Definition: Pure alcohol is a thin, clear, colorless, inflammable liquid, which has a rather weak odor, a burning taste, and an intoxicating effect.

It derives from Arabic word “Alcohol” meaning a finely divided spirit: Around A.D. 800, Arabian chemists figured out how to overcome yeast’s natural limitations by boiling alcohol away from its sugar bath and condensing it into “pure” alcohol. Because pure alcohol isn’t very appetizing (chemists use it in the laboratory as a solvent, an extracting agent, fuel and the starting material for the production of acetic, lacquers, varnishes, and dyes), distillers dilute the spirit with water.

There are many types of alcohol but the alcohol used for consumption is Ethanol (ethyl or grain alcohol)

It is produced in three forms:
Beer from cereals, Wines from grapes, fruits
Distilled spirits from cereals, grains, fruits and molasses

The only difference is the flavor and concentration of alcohol.

DAY 2

Session 4.0  Review of day one (20 minutes)

Session 5.0  Why and when people abuse/drink alcohol  [Duration: 1hr and 30 minutes]

Objective:
• To allow participants gain insight or "enter the world" of people who drink /abuse alcohol

Methodology

Step 1: Ask participants to break into 4 groups and let each group discuss the following questions using flip charts  (Duration: 30 minutes)
Group 1: Why do people drink alcohol?
Group 2: Who are regarded as alcohol abusers?
Group 3: Is alcohol beneficial to health?
Group 4: Is alcohol a stimulant or a sedative?
Step 2: Ask groups to report their findings in plenary (Duration: 30 minutes)

Step 3: Then lecture participants on the common reasons why people drink: (Duration: 30 minutes)

Hand out: Common Reasons for drinking.

Common reasons for drinking:
For culture and tradition- to celebrate religious or social events.
Elegance- enjoying fine liquor or wine with food as a social lubricant- to dissolve tension and raise spirit.
In a religious ceremony e.g. Catholics at Mass.
  • To forget certain feelings:
  • Worry
  • Boredom
  • Guilt
  • Tension
  • Inferiority
  • As temporary relief from problems-escapism.

N.B. Drinking never solves problems, but it usually makes them worse.

As a stimulant, True—in low doses. In low to moderate doses, alcohol is indeed a stimulant, increasing blood flow, accelerating heart rate, and stimulating brain cells to speed up the conduction and transmission of nerve impulses. But alcohol is a sedative, depressant when high doses of alcohol are taken;
It depresses the brain
Impedes judgment and thought
Memory develops little gaps and even some gaping holes, and you feel dizzy, clumsy, and tongue-tied.

As medicine at times:
Increases heart beat rate.
  • Dilates blood vessels.
  • Lowers blood pressure slightly.
  • Stimulates the appetite
  • Increases production of gastric juices.
  • Stimulates urine out put.

Is alcohol therefore beneficial to your health? In certain circumstances, for some people, the answer is Yes, in most circumstances, for most people, however the answer is No. As always
with alcohol, it depends on the dose and the individual. The beneficial effects of alcohol depend on low doses, and only people experience them over the age of 45 years.

To enjoy the taste, to enjoy the change in feelings.
For physical and psychological dependence on alcohol. (these are the alcoholics)

Session 6.0 Disease concept of Alcoholism (1 hour 35 minutes)

Objectives:

To offer participants an opportunity to:
• Become more familiar with the disease concept of alcoholism
• Be able to define alcoholism
• Be able to identify who an alcoholic is.
• Get an insight of stages of alcoholism
• Get to know the signs and symptoms of the disease of alcoholism.
• Gain a better understanding that alcoholism is a disease like any other disease.

Methodology:

Step 1: Ask participants to break into 3 groups to discuss the following questions on the Disease concept of alcoholism (30 minutes)

Group 1. What do people think an alcoholic is? Do you think alcoholism is a disease? If yes why?
If not why?
Group 2. What is a disease? Give examples of disease that you know.
Group 3. How can you tell that a person is suffering from alcoholism and not other diseases?

Step 2: Let participants report their findings in a plenary. (Duration: 20 minutes)

Step 3: Facilitator gives a presentation using a power point projector on the following:
3.1. Disease concept of alcoholism
3.2. Diagnosis: Am I an alcoholic? (The different assessment)
3.3. Stages of alcoholism: Signs and symptoms.
(45 Minutes)

Step 5: Processing the learning from the day. (20 minutes)

Ask the group some of the following questions (project them or write on a flip chart)
• What have you learnt during this session?
• What do you need to clarify?
• How do you feel about alcoholism?
• How do you feel about the methods that have been used in this session?
• Anything else?
• Allow discussion and sharing among participants.

**Hand out on Disease concept of alcoholism.**

In an effort to emphasize the progression of the disease from its early to middle and late stages, the following definition was approved in February 1990 by the Board of Directors of the National Council on Alcoholism and Drug Dependence and the American Society of Addiction Medicine:

Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.

Another definition:
Alcoholism is a progressive neurological disease strongly influenced by genetic vulnerability. Inherited or acquired abnormalities in brain chemistry create an altered response to alcohol, which in turn causes a wide array of physical, psychological, and behavioral problems. Although environmental and social factors will influence the progression and expression of the disease, they are not in any sense causes of addictive drinking.

A disease is defined as:-
Anything that interferes with the ability of the body to function normally. Alcohol actually does this.
Alcoholism is a disease because like other diseases it has a:
• Cause
• Course
• Signs and symptoms
• Outcome
• Treatment
• Therefore it can be defined, described, Diagnosed and Treated.

**World Health Organization’s position**

In 1950’s the World Health Organization (WHO) accepted alcoholism as a disease, which can be:
Defined
Described
Diagnosed (to say exactly what an illness or the cause of a problem is)
Can be effectively treated.

Alcoholism is defined by WHO as:
- Primary
- Chronic
- Progressive
- Terminal
- Incurable
- Hereditary

According to the WHO, it is a primary, chronic, progressive and terminal disease; caused by dependency on the chemical alcohol which is an addictive substance. It affects a person physically, mentally, emotionally, morally and spiritually.
It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite diverse consequences and distortions in thinking, most notably denial.
An alcoholic: This is a person whose drinking frequently interferes with his or her family, life, business, social life or health and spiritual life.

Causes of alcoholism

Alcoholism is caused by biochemical/neurophysiological abnormalities that are passed down from one generation to the next or, in some cases, acquired through heavy or prolonged drinking.
Hereditary or genetic disposition
Consumption of alcohol

Diagnosis of Alcoholism

DIAGNOSIS: AM I AN ALCOHOLIC?

Hand out: Questionnaires (CAGE, 12 Questions, ASSIST, AUDIT, 22 Question)

The CAGE questionnaire
This is a very simple and easy method used in history taking to assess the likelihood of the presence of alcoholism.

C  Have you ever felt the need to Cut down on your drinking?
A  Have you ever felt Annoyed when people criticize your drinking?
G  Have you ever felt Guilty about your drinking or its consequences?
E Do you take a morning drink as Eye Opener?

(One) Yes to the answers- probability of addiction is 62%.
(Two) YES’s have the probability of 80% problem addiction.

The Johns Hopkins University Drinking Scale. (20 questions)

Another questionnaire that many experts consider an effective tool for diagnosis of alcoholism, even in its early and middle stages, is the Johns Hopkins University Drinking Scale. Ask yourself the following questions and answer them as honestly as you can:

- Do you lose time from work due to drinking?
- Is drinking making your home life unhappy?
- Do you drink because you are shy with other people?
- Is drinking affecting your reputation?
- Have you felt remorse after your drinking?
- Have gotten into financial difficulties as a result of your drinking?
- Do you turn to lower companions and inferior environment when drinking?
- Does your drinking make you careless of your family’s welfare?
- Has your ambition decreased since drinking?
- Do you crave a drink at a definite time daily?
- Do you want a drink the next morning?
- Does your drinking cause you to have problems in sleeping?
- Has your efficiency decreased since drinking?
- Is your drinking jeopardizing your job or business?
- Do you drink to escape from worries or troubles?
- Do you drink alone?
- Have ever had a complete loss of memory?
- Has your physician ever treated you for drinking?
- Do you drink to build your self-confidence?
- Have you ever been in a hospital or institution on account of drinking?

Scoring: 3 YES answers indicate a probable drinking problem, according to the designers of this scale. 4 to 7 YES answers indicates early-stage alcoholism; 7 to 10 YES answers indicate middle-stage alcoholism; and more than 10 YES answers indicates late-stage alcoholism.

Stages of alcoholism: Signs and symptoms

Hand out: Stages of alcoholism

Early stage:
- Gulping drinks
- Intense pleasure
• Lower intensity reaction
• Increase in alcohol tolerance
• Preoccupation with alcohol, thinking about the next drink
• Drinking to calm nerves
• Desire to continue drinking when others stop
• Uncomfortable in situations where there is no alcohol
• Relief drinking commences
• Occasional memory lapses after heavy drinking
• Secret irritation when your drinking is discussed.

**Middle stages:**

• Loss of control phase
• Blackouts-memory loss
• Personality disintegration
• Denial (minimizing, projection, rationalization, intellectualization, diversion-lying about drinking, hostility and aggressive behavior, avoidance-family and friends avoided and drinking alone, complying, manipulation, democratic right, scapegoating)
• Withdrawals- when blood concentration level begins to descend there is (anxiety and irritability, restlessness and tremors and early morning drinks, nervousness and weakness, insomnia and gastrointestinal distress, loss of appetite, elevated blood pressure and exaggerated reflexes)
• Hiding liquor: sneaking drinks
• Increasing dependency on alcohol
• Feeling guilty about drinking
• Promises and resolution fail repeatedly
• Loss of other interests/unable to discuss problems
• Family, work and money problems
• Neglect of food/controlled drinking fails
• Possible loss of job

**Late stage of alcoholism:**

**Late stage of withdrawals**

• Craving- overwhelming desire to drink, successive lengthy drunks
• Loss of control in both his USE and BEHAVIOUR, cannot fully determine WHAT, WHEN, WHERE WITH WHOM.
• Complications—liver, heart, brain, kidney, nerves, stomach, pancreatic, etc.
• Radical deterioration of family relationships
• Unreasonable resentments
• Physical and moral deterioration
• Loss of will power and on set lengthy of drunks
• Urgent need for morning drink
• Geographical escape attempted
• Persistent remorse, feeling sorry
• Impaired thinking and memory loss
• Loss of family
• Decrease in alcohol tolerance
• Indefinable fears
• Unable to initiate action: extreme indecisiveness
• Unable to work, obsession with drinking
• All alibis exhausted
• SUICIDE
• HOSPITALIZATION
• DEATH.

DAY 3

Session 7.0  Craving, withdrawals and Detoxification (Duration: 1hr and 30 minutes)

Objectives:
To offer participants an opportunity to:
• To begin to understand Craving and why people continue to drink
• Identify the dangers associated with Withdrawals
• Understand the role of detoxification in the process of recovery..

Methodology:

Step 1: Ask participants to break into 3 groups and discuss the following questions:-

Q.1. What do you understand by craving? Describe the experiences of people who are in craving when they telephone.
Q. 2. What do you understand by the term “withdrawals”? Do you think craving and withdrawals have a relationship? If so describe the relationship. If not, give your reasons.
Q.3. What is detoxification? What category of people do you think need it?
   
   Duration: 30 minutes

Step 2: Let participants present their findings in a plenary (Duration: 30 minutes.)

Step 3: Using a power point, Give a summarized lecture on Craving, Withdrawals and Detoxification
   (Duration: 30 minutes.)

Handouts : A hard copy on the topic session will be given out to participants)
Session 8.0  Alcohol’s Journey through the body (Duration: 1hr and 40 minutes)

Objectives:

- To offer participants an opportunity:
- Gain insight in alcohol’s journey through the body.
- Know more about alcohol’s relationship to the body weight and gender.
- Access information on how the body eliminates alcohol.
- Learn about alcohol and the brain.

Methodology

Step 1: In a brainstorming session ask participants to share on what they think happens to alcohol when one drinks alcohol. Capture the answers on newsprint (Duration: 20 minutes)
Step 2. Then lecture to participants what really happens when you drink. (60 minutes)

Using a projector and a flip chart, on the following
- Alcohol’s journey through the body: Metabolism
- The addicted brain.

Step 3: Process the day's activities and evaluation (20 minutes)

Step 7: Facilitator gives a hand out:

Alcohol stays in the stomach briefly and passes on to the bloodstream unchanged – unlike food. Within a few minutes it is pumped from the big toe to the brain where it depresses the central nervous system that controls behavior.

About 80% travels down into small intestines and quickly enters the bloodstream. Blood carries it directly to tissues, organs and secretions of the body and to the brain, where it slows down mental activity.

It is then gradually and continually changed (oxidized) chemically in the liver and in other tissues into carbon dioxide and water. The remainder is excreted through urine respiration and breath.

Only food can help slow down the absorption rate of alcohol in the blood. Few people have pylorus—a muscular value separating the stomach from the intestine—that prevents intoxication.
Five to ten percent of the alcohol you drink is absorbed into the bloodstream through the lining of the mouth and esophagus. Approximately 20% is absorbed into bloodstream in the stomach, although the rate varies according to gender. The remaining 70% to 75% is absorbed through the walls of the small intestines. When alcohol mixes with your bloodstream, your alcohol concentration (BAC), also known as blood alcohol level (BAL), rises. BAC is the amount of alcohol in the bloodstream, measured in percentages. A BAC of 0.10%, for instance, means, that a person has 1 part alcohol per 1,000 parts blood in the body. How quickly and how high your BAC rises depends not only on how much you drink and percentage of alcohol in the drink, but on weight, body fat, gender, age, nutritional status, physical health, and emotional state.

Weight: The more you weigh, the greater your blood volume, the more liquid there is to dilute alcohol. A 200-pound man has more litres of blood circulating in his body than a 150-pound man; the more blood there is to dilute the alcohol, the slower the rise in BAC.

Body fat: Alcohol does not dissolve as readily in fat as it does in water, muscle, or bone. Alcohol is a polar molecule (one end is positively charged and the other end is negatively charged) and easily dissolves in other polar substances such as water. Fat on the other hand, is non polar, and alcohol has difficult time getting into fatty tissues; more of it will remain in your blood stream instead. As a result the greater the amount of body fat you have, the higher you BAC will be.

Gender: Even if a man and woman weigh the same and drink the same amount, the woman will have a higher BAC for two basic reasons. First, women have smaller amount of body water to dilute the alcohol (somewhat like mixing the same of alcohol into a smaller pail of water). Women also tend to have a higher percentage of body fat; as explained above, alcohol does not dissolve readily in fat, so concentration of alcohol in the blood stream will be greater. A woman’s BAC will also vary according to the phases of her menstrual cycle. The highest BACs occur during the premenstrual phase. Because hormone levels can vary day-to-day and month to month (and BACs vary with them), women are less able to predict accurately the effect of a given amount of alcohol.

Age: Body fat typically increases with age while enzyme actions tend to slow down, as you get older. As a result, a few drinks will hit you harder at age sixty than they will at age thirty, forty, or fifty. Although teens and preteens are not fully-grown, their livers can process alcohol just as well as adult drinkers. The problem with teenagers is that they tend to drink large quantities of alcohol in very short periods of time, leading to rapid intoxication, vomiting, loss of consciousness, and even death.

Nutritional Status: If you eat when you drink, alcohol mixes with the more complex food molecules, which slows down the rate at which the stomach’s contents empty into the small intestine. Since 70 to 75 percent of alcohol is absorbed through the small intestine, this delay results in a slow rise in blood alcohol concentration. If you drink on an empty stomach (the 5:00 P.M. happy hour), the process of absorption is faster because there are fewer competing food molecules and circulating enzymes in the stomach to slow the absorption process. As a result, alcohol is released immediately into the small intestine, where it is rapidly absorbed into the bloodstream.
Health of the stomach, intestines and bowel: Ulcers and bowel disorders such as colitis, crohn’s disease, and irritable bowel syndrome create raw, irritated surfaces in the bowels, which make these surfaces more permeable or “leaky”. This leads in many cases to higher BAC.

Emotional state: Anxiety, fear, anger, stress and fatigue signal the body to release the hormone epinephrine (adrenaline). Adrenaline mobilizes fats and glycogen (the body’s primary source of sugar) for energy use, diverting blood away from stomach and intestines into skeletal muscles; this reduced blood flow will slow down the process of alcohol absorption. However, chronic and intense emotional states may have the opposite effect, damaging the stomach and intestines, and thereby speeding up absorption.

Drink strength: The stronger the drink is—that is, the more alcohol it contains—the greater the amount of alcohol that will get into your blood stream. In distilled spirits (scotch, whisky, Uganda waragi, gin etc.) the alcohol molecules make up a much larger percentage of the total volume; in addition, most distilled liquors do not contain amounts of complex sugars or carbohydrates, which are present in wine and beer and help slow down absorption through the stomach and intestine.

How the body eliminates alcohol, Metabolism: Think of a bloodstream as a fast flowing river crammed with barges of nutrients and chemicals that require unloading and processing at the liver, an incredibly efficient factory. When alcohol is present in the blood stream, it zips in and out of the steady flow of traffic like a speedboat with a thrill-seeking teenager at the wheel. The heavily loaded barges move out of the way, allowing alcohol to pass quickly through the congestion and gain easy entry to the liver.

If one or two speedboats enter the bloodstream, the liver has no difficulty stripping them down into scrap metal. If the speedboats keep coming, however, the liver has a traffic jam on its hands. A normal healthy liver can process alcohol at the approximate rate of 0.5 ounce of pure alcohol per hour, the equivalent of one 12-ounce beer, 5 ounces of table wine, or 1.5 ounces of 80 proof distilled spirits. Thus, if you drink one and half cans of beer, 6 ounces of wine, or 2 ounces of 80 proof gin in one hour or less, that’s more alcohol than your liver can process. The remainder will circulate in your blood stream until your liver is ready to deal with it. If you continue to drink, your BAC will continue to rise.

In the liver, the metabolism (breakdown and elimination) of alcohol is controlled by dozens of different enzymes and isoenzymes. These enzymes and iso-enzymes are under genetic control—specific genes or combinations of genes will determine the enzymes and isoenzymes you will have and in what relative proportion. Each of these enzymes directly affects the way you metabolize alcohol, which in turn controls your subjective experience of drinking. Thus your individual reaction to alcohol is determined in large part by your enzymes, which are in turn controlled by the genes you inherit from your parents.

The addicted brain:
For hundreds, even thousands of years, people have argued loud and long that alcoholism is a shameful personal weakness, a stubborn character defect, or a symptom of some underlying moral disorder. Alcoholics, because they “choose” their fate (unlike the innocent victims of epilepsy, heart disease, or cancer), rank low in the moral order. “Every human soul is worth saving” proclaimed J.E. Todd more than a hundred years ago in a tract titled Drunkenness a Vice Not a Disease, “but...if a choice is to be made, drunkards are about the last to be taken hold of”. The shame and stigma associated with alcoholism have persisted despite the fact that we know, from hundreds of studies conducted by thousands of researchers, that alcoholism is a progressive, physiological, genetically determined disease and not a moral or personal weakness. The stunning discovery in 1990 of a gene mutation associated with alcoholism provides an avenue of fertile investigation into the potential biochemical, neurophysiological, and genetic roots of alcoholism. Researchers haven’t mapped out all the genes involved, nor do they know the precise pattern of genes that combine to create varying degrees of susceptibility of alcoholism. They do know, however, that certain genes or gene combinations determine whether or not a specific individual will be predisposed to the disease of alcoholism.

A Neurological disease:
The human brain is composed of billions of nerve cells, or neurons, which are responsible for two major functions: (1) sending messages to other neurons and (2) receiving messages from other neurons. To send or receive messages, the brain relies on a system of specialized “messenger” chemicals called neurotransmitters. The most important neurotransmitters involved in alcoholism are dopamine, serotonin, norepinephrine, and GABA.

Dopamine intensifies feelings of well-being, increases aggression, alertness, and sexual excitement and reduces compulsive behavior.
Serotonin promotes feelings of well-being, induces sleep, reduces aggressive and compulsive behavior, and elevates the pain threshold.
Norepinephrine increases feelings of well-being and reduces compulsive behavior; in excess, norepinephrine may induce anxiety and increase heart rate and blood pressure.
GABA reduces anxiety and compulsive behavior and raises the pain threshold.

When a neurotransmitter is released from the neurons, it searches for the receptor with right shape and electrical charge to receive its information. When it finds the correct address, the neurotransmitter pulls into driveway and unloads its packages into the open door of the receptor cell. That’s the short course on normal brain chemistry.

Something different, however, happens in the alcoholic’s brain. When an individual with a genetic disposition to alcoholism drinks—and remember, by definition, a genetic predisposition exists before the person ever takes the drink—strange and unusual events occur in the brain. The first part of this story begins with acetaldehyde, the metabolic by-product of alcohol.
When alcohol is metabolized (broken down) in the liver, it is converted first to acetaldehyde.
Acetaldehyde’s actions in the brain are critically important for understanding the process of addiction. Rough, tough, quick, and dirty, acetaldehyde is the ultimate party crasher. In the fiercely productive orgy that ensues between the neurotransmitters and acetaldehyde, a new generation of chemicals is created. Scientists call these chemicals tetrahydroisoquinolines, or TIQs.

No wonder the brain cells are so accommodating to the TIQs—chemically, they are almost the spitting image of a family of sleep-inducing, pain relieving addictive compounds known as the opiates.

Like the naturally occurring opiates (the endorphins and enkephalins) and the synthetic opiates morphine and heroin, TIQs are addictive substances that can induce excessive drinking behavior. If TIQs are formed in sufficient quantities in certain crucial areas of the brain, they may induce changes in brain chemistry that will generate a pathological craving for alcohol, despite its bad after effects. This may well be the pattern that creates human alcoholism.

**What the brain does:**
As the center of the nervous system, the brain controls everything that goes on inside the body, whether mental or physical. Though the multitude functions of the brain are most complex, it will serve our purpose to divide them into three “layers”, bearing in mind that the whole of the brain is somehow involved in all of its functions:

The top layer: “houses” the non-muscular functions of the body: the mental processes e.g. thinking, reasoning, memory, awareness, common sense, the psychological processes e.g. inhibitions, emotions, habit, caring (it is our ability to care that makes it possible for us to have a sense of duty, responsibility, loyalty, decency and self respect).

The middle layer: coordinates those muscles called “voluntary”, all those we use deliberately, as in walking, digging, just plain sitting…. and swallowing.

The bottom layer: of the brain controls the “involuntary” muscles that have to do with vital functions e.g. digestion, breathing, heartbeat, the functions that go on even during our sleep.

**What alcohol does to the brain:**
The higher centres of the brain are the first to be affected by alcohol. As the percentage of unprocessed alcohol in the blood increases, the other two layers are reached and, while the alcohol is gradually sedating the top layer it is also reducing the activity of these two layers. It does not work on only one layer at a time. The anaesthetic effect of alcohol starts with the functions of the top level and, while that are still going on, the next level is affected and then the third.

**Stages of intoxication:**
Stage 1. HAPPY. Talkative, sociable (because of alcohol’s initial stimulant action). Relaxed. Fewer inhibitions and worries. Some loss of judgment, common sense and efficiency.
Stage 2. FEELING HIGH. Emotional, erratic behavior. Thinking is impaired. Reactions are slowed. Poor judgment. Loss of control over actions.
Stage 3. CONFUSED. Staggering, loss of sense of direction, drowsy, less concern with or awareness of surroundings. Exaggerated fear, anger, etc. Slurred speech, “Double” vision. Weepy/giggly. (At this stage the drinker is drunk).


Stage 5. IN A COMA. Completely unconscious, so deeply that it is impossible or extremely difficult to arouse the drinker. Shallow breathing. Weak pulse.

ALARM: Anyone that reaches this stage is in IMMEDIATE DANGER OF DEATH from respiratory paralysis, because the rest of unprocessed alcohol in the blood stream keeps on deadening the brain. Keep the victim AWAKE by whatever means e.g. very strong coffee, walking him up and down. Rush him to the nearest hospital. And pray.

EXPLAIN TO PARTICIPANTS HOW THE STAGES OF INTOXICATION CLEARLY DEMONSTRATE THE RELATIONSHIP BETWEEN SUBSTANCE ABUSE AND HIV/AIDS BECAUSE OF IMPAIRED THINKING AND POOR JUDGEMENT. THIS LEADS TO IRRESPONSIBLE SEX. ALLOW DISCUSSION.

DAY 4:

Session 9. Alcohol and Your liver [Duration: 60 minutes]

Objectives:
- To offer participants an opportunity to:
- Learn more about alcohol and the liver/metabolism

Methodology
Step 1: Brainstorming. Ask participants to tell anything they know about alcohol and the liver. 
Duration: 20 minutes

Tell them that the alcohol you just drank is now in your blood stream. We know what happens to it: 90% of it is metabolized and detoxified, made harmless by the liver, at the rate of 30cc of pure alcohol per hour, and 10% is eliminated with water that carries it.

Step 2: Present a case study of someone who died of the cirrhosis of the liver. 
(Duration 20 minutes)

Step 3: Then summarize the information on alcohol and the liver (Duration: 20 minutes)

Hand out:
Facilitates issues out a handout on Alcohol metabolism and the functions of the liver. The liver is the largest organ in the body and performs more functions than any other organ. It is an incomparable chemical plant and can modify almost any chemical structure. It is a powerful metabolism and detoxifying organ, breaking down many kinds of substances to provide energy, and making toxic molecules harmless. One of its functions is the destruction of old blood cells and the preparation and storage of what the bones will need to make new ones. It manufactures the elements necessary for blood clotting, without which one could bleed to death from a small cut (the disease of hemophiliacs). Other elements it manufactures: enzymes, cholesterol, proteins, bile that assists digestion. It stores some vitamins and digested carbohydrates which it releases as needed to sustain blood sugar levels. It is essential in changing carbohydrates, proteins, fats and minerals to energy (calories). It has the uncanny and unique ability of repairing and renewing itself.

How the liver s affected by alcohol
The liver keeps getting messages from all over the body by way of the blood that flows from it. Thus it “knows” “who” needs what, and so it sets about providing what is required. It can handle many operations at the same time, like the giant chemical factory, which in effect it is. If an urgent order comes to a chemical factory for a substance not scheduled to be produced at that moment, other operations will have to be curtailed or suspended while this material is produced. Too many orders of this kind could disrupt, or even wreck, the smooth operation of the factory.

So it is with the liver. When alcohol reaches it, it goes to work to get rid of it-IT’S A POISON! It can handle a certain amount of it without strain for a certain time. Then it gets tired, it gets sick, it becomes inflamed and enlarged, etc…CIRRHOSIS! And that spells trouble in the chemical factory, BIG TROUBLE! That’s bad news, because it is often permanent and serious condition…worse news: it is often FATAL. Not all heavy drinkers develop cirrhosis of the liver, and some non-drinkers may contract it, but it happens to eight heavy drinkers for every one non-drinker. It can develop after five or more years of heavy drinking.

What happens to every liver that is metabolizing and detoxifying alcohol is that it is not carrying out some other of its usual functions. Thus the rest of the body is adversely affected. For instance, blood sugar is lowered, causing hypoglycemia, common among heavy drinkers; fat accumulates, the “beer belly” that can develop after several weeks of heavy drinking. Even the liver’s ability to metabolize and detoxify alcohol can be impaired, leading to alcohol poisoning and even death.

Go back to the paragraph on the functions of the liver and at each function stop and say: “This function of the liver is affected in a bad way by alcohol, by any amount of alcohol, and worse by a greater amount”. If you are a drinker, even a moderate one, I hope that this knowledge does not disturb your sleep.
Session 10 : Effects and Consequences of Alcoholism/ [Duration: 2:30min ]

Objectives:

- To offer participants an opportunity to:
- Identify the harm caused by alcohol and other substances.
- Identify the destructive consequences of alcoholism and substance abuse

Methodology

Step 1: Role play: Select a few participants (3-4) to act as alcoholics and drunk depicting what happens to an alcoholic who is still suffering (20 minutes)
Step 2: Let participants comment on the drama they have just seen (10 minutes)
Step 3: Ask participants to break into 3 groups and discuss the following questions
   Group 1. What happens when one is intoxicated? What injuries do alcohol and drugs cause to the body?
   Group 2. Describe the family of an alcoholic father.
   Group 3. Does alcoholism/drug addiction affect the employment/career of an individual? If so how?
   (Duration: 40 minutes)

Step 4: Ask participants to report to the plenary (20 minutes)
Step 5: Let Participants ask questions where it's not clear to them (10 minutes)
Step 6: Using Flip chart, give a lecture on the effects and consequences of alcoholism (20 minutes)

Inform the participants that the safe amount of alcohol and the point at which it causes damage is impossible to estimate because it varies with the individual’s genetic history, height, age, health, use of other drugs, environment etc. However, chronic drinking causes damage to virtually every organ in the body.

Handout

Effect of intoxication:

- Slurs speech
- Changes behavior
- Weakens muscles
- Reduces awareness
- Brings one in a comatose state and causes death through respiratory paralysis.

Nutritional consequences:
Loss of appetite
Undernourishment

**Injury to tissues and organs of the body:**
Central nervous system
Peripheral nervous system
Gastrointestinal system
Cardio (connected with heart) vascular system
Liver and pancreas.

**Other factors:**

Immune system disorders:

Chronic drinkers are much more susceptible to infection diseases and certain cancers. It inhibits the mobilization of leukocytes, and weakens all mechanisms of cellular immune responses. Alcohol causes high-risk infectious diseases e.g. pneumonia. Etc
Causes high-risk cancers of liver lung, breast, tongue, throat, stomach, pancreas and mouth.
Male reproductive system: it destroys the function of cells that produce testosterone leading to impotence, decrease amount of mature sperm, abnormal immature sperm, development of female hair patterns, breast enlargement and infertility.
Female reproductive system: it leads to dysmenorrhea (pain during menstruation) heavy flow of blood premenstrual discomfort, and hormone imbalance, as well as amenorrhea (absence of menstrual period).
Pregnancy: alcohol can lead to miscarriage, premature births, and underdeveloped fetuses. Babies of moderate drinkers may suffer from low birth weight and delayed development of the central nervous system. These babies may also be hyperactive and have learning disabilities. Babies of alcoholic mothers may suffer from fetal alcohol syndrome, which includes gross physical deformities, handy caps mental retardation. Even small amounts of alcohol during pregnancy can be dangerous to the fetus.
Health breaks down- a person is too weak to consume.
Wealth finishes- poverty
Freedom is taken away- imprisonment or hospitalization.
Using moderately:
Increase heart rate slightly
Lowers blood pressure
Dilates blood vessels in legs, arms and stomach
Increase appetite
Stimulates urine output
Boasts production of gastric secretion
Using alcohol heavily
Enlarges the heart due to toxic effect: heart failure
Enlarges the liver due to fatty deposits
Blurs vision and general dimness due to fatty deposits in eye tissues and vitamin deficiencies.
Hearing difficulties accompanied by equilibrium problems.
Neuropathy, numbness, tinkling, burning pains and weakness in the extremities.
Seizures similar to epilepsy
Gastritis and abnormal pain
Insomnia
Anxiety
Itchy skin
Heavy perspiration
Hypoglycemia- abnormally rapid fall in the blood sugar level resulting into nervousness weakness perspiration, mental confusion, fatigue agitation and depression.
The DT’s delirium tremens-a violent mental disturbances characterized by confusion and hallucination.

Long term use:

Liver cirrhosis and other liver damage like alcoholic hepatitis due to fatty deposits on the liver. Weakness, loss of appetite and jaundice.
Brain-alcohol kills the brain cells by oxygen starvation, it depresses the nervous system and leads to brain damage, Korsakoff’s syndrome.
Mouth and throat cancer as those who smoke pharynx and esophagus.
Muscles weaken- constant falls.
Stomach- alcoholic gastritis, inflammation of the stomach lining, stimulation of the formation of acid by the pancreas.

Consequences of alcoholism and substance abuse

Family relationships
Financial difficulties
Children with defective behaviors
Child of spouse abuse
Decreased social life
Divorce

Employment/ Career life

Absenteeism
Poor performance
Loss of job
Frequent job changes
Periods of unemployment

Society and legal relationships
Frequent auto accidents
Assault changes
Disorderly conduct
Public drunkenness citations

**Personal health problems**

Malnutrition
Convulsion
Impotence
Mood swings
Insomnia/ sleeplessness
Depression
Heart and liver failure
Hospitalization
Suicidal attempts
Death.

Step 7: Processing the learning of the day (Duration: 30 minutes)
Ask the participants to reflect on the following questions:
- What have been the most important learning points from the day?
- What do you still need some clarification about?
- What parts of the day have you enjoyed most?
- What parts of the day have you enjoyed least?
- How do you feel about the effects and consequences of substance abuse?
- Anything else?
DAY 5

Session 11. Introduction to the 12 steps Alcoholics Anonymous (AA) Recovery Program: (Duration 3 hours)

Objectives:
To offer participants an opportunity to:

- Gain knowledge on the AA 12 Step program to be used during the online counseling of alcoholics.
- Inform participants about the existing or available help in the country
- Learn from the knowledge, attitudes and practices of international communities managing alcoholism
- Understand the 12-traditions

Methodology

Step 1 Ask the participants to break into 4 groups and discuss the following questions:
Group 1. What kind of help is available for alcoholics and drug addicts in your communities?
Group 2. Is it possible for an alcoholic to stop drinking? If so how?
Group 3. What should government do to reduce the problem of alcoholism/drug addiction?
Group 4. What do the majority of families do, when one of their members is an alcoholic or a drug addict? (Duration: 40 minutes)

Step 2: Participants report back in a plenary, to share their findings. Duration: 30 minutes

Step 3: Then lecture on 12 step program of recovery (Duration: 60 minutes)

Alcoholism treatment does work, and the great majority of alcoholics do recover from their disease-if they are offered the right treatment. It really is that simple: With right treatment, most alcoholics can recover. With wrong treatment, most alcoholics will relapse and return to drinking.

Hand out:

Levels of treatment
Personal willingness to get treated
Admission of powerlessness
Alcoholic Anonymous (AA) fellowship and 12 step programme.
Alnon groups
Support groups such as Pioneer Movements, Charismatics, Savedees, NGOs that deal in alcohol reduction
Hospitals- for detoxification such as Butabika
Attending to a Psychiatrist
A 90 Day Programme at Treatment Centres e.g. National Care Centre: counseling and therapy.
Sponsorship in AA

The addiction treatment programmes: The Minnesota Model.
The techniques used by James Milam at Alcenas Hospital 25 years ago are similar to those used today at such successful clinics as the Betty Ford Center in California, Hazelden in Minnesota, Sundown M Ranch in Washington State, and scores of comparable treatment centers across the land. These addiction treatment programmes are organized under the general principles of a treatment system called the “Minnesota model”. The state of Minnesota recognized alcoholism as a disease very early, just after the American Civil War. As early as 1873 Minnesota imposed a tax on saloons and used the proceeds to build and operate a “treatment center for inebriates” in Rochester. After its founding in the early 1930s, Alcoholic Anonymous flourished in Minnesota, and AA members were instrumental in spreading the word about the physiological nature of the disease. Minnesota eventually became known as the “land of ten thousand treatment centers”

The basic tenets of the Minnesota model:
Alcoholism is an involuntary, primary disease that is describable and diagnosable.
Alcoholism is a chronic and progressive disease. Barring intervention, the signs and symptoms of alcoholism self-accelerate.
Alcoholism is not curable, but the disease may be arrested.
The nature of the alcoholic’s initial motivation for treatment—its presence or absence—is not a predictor of treatment outcome.
The treatment of alcoholism includes physical, psychological, social, and spiritual dimensions.
The successful treatment of alcoholism requires an environment in which the alcoholic is treated with dignity and respect.
Alcoholics and addicts are vulnerable to the “abuse” of a wide spectrum of mood altering drugs. This whole cluster of mood-altering drugs can be addressed through treatment that defines the problem as one of chemical dependency.
Chemical dependency is best treated by a multidisciplinary team whose members develop close, less-formal relationships with their clients and whose activities are integrated within an individualized treatment plan developed for each client.
The focal point for implementing the treatment plan is an assigned primary counselor, usually recovered, of the same sex and age group as the client, who promotes an atmosphere that enhances emotional self-disclosure, mutual identification, and mutual support.
The most effective treatment for alcoholism includes an orientation to A.A., an expectation of “Step work”, groups that combine confrontation and support, lectures, lectures, one-to-one counseling, and the creation of a dynamic “learning environment”.
The most viable, ongoing, sobriety-based support structure for clients following treatment is Alcoholic Anonymous.
The 12 Steps of Alcoholic Anonymous.

Step 1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
Step 2. Came to believe that a Power greater than ourselves could restore us to sanity.
Step 3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
Step 4. Made a searching and fearless moral inventory of ourselves.
Step 5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
Step 6. Were entirely ready to have God remove all these defects of character.
Step 7. Humbly asked Him to remove our shortcomings.
Step 8. Made a list of all persons we had harmed, and became willing to make amends to them all.
Step 9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
Step 10. Continued to take personal inventory and when we were wrong promptly admitted it.
Step 11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the Power to carry that out.
Step 12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Step 4. Lecture participants on the Traditions of AA. (20 minutes)

Step 5. Processing the learning of the day (Duration: 30 minutes)

Ask participants some of the following questions

- How have activities today helped you?
- What have you enjoyed?
- What have been the difficulties?
- How were these overcome?
- What have you learned?
- How will you use this learning in your work?
- Anything else?

DAY 6

Session 12  DENIAL: (Duration: 3hrs and 30 minutes)

Objectives:
• Define denial and its processes
• Ensure Participants gain insight on the impact of denial to an alcoholic
• Reveal Interventions in Intervention: Breaking through Denial

Methodology:

Step 1: Ask participants to break into their groups and discuss the following questions
Group 1. What do you understand by the term “denial”?
Group 2. Why do some people refuse to accept that they have a drinking/drugging problem
Group 3. What suggestions would you give to the employer with an alcoholic employee?
Group 4. How can you deal with an alcoholic who constantly pesters you for material needs like food, clothing, money and accommodation?

Duration: 40 minutes

Step 2: Participants come back and present their findings in a plenary (20 minutes)
Step 3: Then inform participants about the following

Duration: 30 minutes

Hand out:

Why people refuse to admit they have a drinking/drugging problem.

1. Failure of courage: To face an illness requires great courage. Most people are unable and unwilling.
2. Not witnessing a good first step: Not yet witnessed first step taken by someone, and have no real model.
3. Inadequate preparation: One needs to carefully study one’s own past and put himself/herself in front of a mirror.
4. Denial of impact: Minimizing of one’s past drinking life
5. Holding on to a major secret especially if it raises a lot of shame. Distrust of your group.

Intervention.
Many alcoholics are not so fortunate to accept early to go into treatment. Alcohol creates serious problems in their lives, but family members, friends, and health care practitioners hesitate to mention the dreaded word alcoholism. The disease progresses, the alcoholic’s problems worsen, and still no one makes a move to help. Even when the alcoholic’s problems are obvious to all close observers, people stand by and watch, unsure about what they can do to help, concerned that anything they might say or do will eventually backfire.

There is an old theory that alcoholics have to hit bottom before they can accept the reality that alcohol is destroying their lives. The theory is based on a misguided notion that alcoholics have to want to get help, before they can commit themselves to sobriety.
The theorists urge that if someone forces you into treatment, you are being coerced against your will and denied the opportunity to use your will power and self-control to seek help for your problems. They forget that alcoholism is a progressive neurological disease. Willpower is as powerless to alter the neurochemical changes in alcoholics, as it is to stabilize blood sugar fluctuations in diabetics or heart fibrillations in coronary patients.

Waiting until the alcoholic is ready to quit drinking is a dangerous strategy. Over the years the hit-bottom theory has cost many alcoholics their lives—for every alcoholic who hits bottom and sees the light, dozens more are destroyed on the way down. Even if you hit bottom, there is no guarantee that you will automatically come up again.

Intervention is a technique designed to help alcoholics before they hit bottom. Intervention is a process of education and enlightenment in which family members, friends, and co-workers learn about the disease of alcoholism and the symptoms associated with its early, middle and late stages. Once the alcoholic’s family and friends learns the true nature of the disease, they are able to see the addiction—not the alcoholic—is the true enemy.

When the family members understand that the alcoholic is sick and will get sicker if the drinking continues, they realize the importance of getting help for both the alcoholic and themselves. Creating a treatment plan does this.

Intervention happens in different ways:
Informal intervention, in which physicians, friends, and colleagues offer their concern and support.
A crisis intervention is more immediate and forceful. When an alcoholic or family member is in crisis—an emergency-room admission for heart attack, for acute hepatitis, or for a bone-breaking fall while intoxicated, a drunk-driving charge, a potentially violent child custody situation, a suicide attempt—an intervention can be arranged to provide immediate emergency assistance. A formal intervention, generally involves several weeks of planning and preparation. The first step is to find a counselor who will guide the family through that intervention process, educate them, and encourage them to build a support system and provide necessary information.

Essential elements involved in actual intervention are:

1. The facts and data must be presented by people who are close to the alcoholic. These are family members, friends, bosses, supervisors, coworkers, physicians, clergy members, and so on.
2. Specific firsthand evidence is especially convincing—descriptive of events, which have happened, or conditions, which exist.
3. Everyone, involved in the intervention should avoid moral judgment and any tone of censure. Facts used should indicate why family members and friends are concerned. Here is an example: “Peter you hit me in the face while you were drunk.
4. Whenever possible the facts should centre on the use of alcohol.
5. Vivid details are particularly effective, e.g. pictures taken while the fellow was drunk.
When family and friends are properly educated and the facts are carefully gathered and lovingly presented, a formal intervention can be extremely effective.

Step 4: Ask the participants to role play on Intervention. (Duration: 60 minutes)

Step 5: Facilitator introduces the "The six selves" intervention skill on: Physical Health, Emotional Health, Social, Family Health, Psychological health, and Spiritual

Duration: 40 minutes

Step 5: Processing the learning from the day. (Duration: 20 minutes)

Suggest that the group may wish to spend sometime looking back through the activities that they may have participated in during the day. They may wish to work individually, in pairs or in small groups to reflect on the learning from the day.

Ask for any reflections, and then thank the group for their participation and hard work throughout the day.

DAY 7 Session 13. The Addiction Tree (Duration: 3hrs.

Objectives:
• To offer participants an opportunity to understand what addiction means and its underlying damage of shame of the alcoholic
• Reveal the Wounding and division within an individual
• Reveal the "faulty interpersonal relationship of an alcoholic
• Become familiar with types of addiction.
• Become conversant with substance abuse addiction.

Methodology:

Step 1: Ask participants to break into groups and discuss the following questions:- Duration: 40 minutes
Q.1. What do you understand by the term "addiction"?
Q.2. What do you think are the commonest weaknesses of human beings?
Q.3. What do you think people get addicted to?
Q.4. Do you think addiction is in born? If so why? If not why?

Step 2. Participants present their findings in a plenary. (50 Minutes)
Step 3. Lecture participants on The Addiction Tree (50 minutes)

**Hand out: What people get addicted to.**

Addictive illness makes our lives unmanageable. We find our lives ourselves hooked to something and it becomes impossible to leave it. We become obsessed. Below is what people tend to get addicted to:
- **People** (People addiction involves relations, lie, sex, co-dependent)
- **Substance** (Substance addiction involves alcohol, marijuana, nicotine, caffeine, food, cocaine, barbiturates, heroine and other mood altering drugs). These substance abused are also termed as chemical dependency or in other words addiction to the substances of choice.
- **Activity** (Activity addiction involves work, exercise, crime, gambling, buying and selling.
- **Thought** (Thought addiction involves perfectionism, obsessive thinking, rigid thinking, worrying, repetition and fantasy.
- **Feeling** (Feeling addiction involves anger, rage, guilt and fear.

N.B. All these underlying damage of shame wound and divide the individual.

Step 4: Processing the learning from the day (40 minutes)
Suggest that the group may wish to spend sometime looking back through the activities that they have participated in during the day. They may choose to work individually, in pairs or in small groups and reflect on the main learning from the day using some of the following questions:-

What have been the most important learning points from the day?
What do you still need clarification about?
Which parts of the day have you enjoyed most?
Which parts of the day have you enjoyed least?
How do you feel now compared to the start of the workshop?

What have been the difficulties?
How were these overcome?

How will you use this learning in your work?

Anything else?

Step 7: Ask participants if anyone would like to make any comments in response to any of the questions. Thank the group for their participation during the day.
DAY 8

Session 14.0 Relapse and Triggers  (Duration: 3 hrs,)

Objectives:

To offer participants an opportunity to:
• Understand what relapse issues are
• Learn how to manage and prevent relapse cases.

Methodology

Step 1: Ask participants to break into groups and discuss the following questions:- (40 minutes)

Q.1. What do you think triggers a relapse?
Q.2. What do you understand by being honest to yourself in recovery?
Q.3. How do you think negative feelings can be a source of relapse?
Q.4. What do you advise on renewing old friendships for someone who has just sobered up?

Step 2. Let participants present their findings in a plenary. (50 minutes)

Step 3: Lecture participants on Relapse and lapses that can trigger a relapse (60 minutes)

Hand outs:

What is relapse?
Relapse is a medical term describing the return of signs and symptoms of a disease after an apparent recovery. You can have a relapse with the flu—and you can have one with the disease of alcoholism/addiction. In neither case is the prognosis grave. It’s likely you will recover from both, but while the flu will probably be self-limiting and go away on its own, you’ll have to take a very positive steps to recover from relapse into alcoholism/addiction.

Lapses that can trigger a relapse:

Dishonesty: Be true to yourself. It is necessary to be truthful with others—at home, at work, at play. Failing to confide the truth, nothing but the truth, to those trying to help you—physicians, counselors, sponsors, others in AA—is another way dishonesty can sabotage recovery. Those with successful recoveries will testify that absolute honesty is the single most important factor in preventing relapse.
HALT: Hunger, Anger, Loneliness, or Tiredness can make you vulnerable to relapse, so be sure to guard against each of these.
Unrequited thirst: Finding yourself thirsty (especially hot and thirsty) with nothing to drink but a frosty beer can be extremely risky. So avoid such situations by being sure that you are well supplied with frosty sodas, juice, or ice water. If necessary bring your own thermos.

Negative feelings: Resentment, ingratitude, self-pity (telling yourself you’re the victim of bad luck rather than someone who’s made poor choices), pessimism, impatience (you crave instant gratification—one day at a time isn’t good enough), frustration (“Why can’t everything go just the way I want it to?”), are all attitudes that can undermine recovery. If you don’t acknowledge these feelings and deal with them quickly and constructively, they will inevitably lead you over edge of Relapse Cliff.

Unrealistic expectations: Expecting too much to soon (a trait typical of alcoholics/addicts) can lead to disappointment and resentment, which in turn can lead to the nearest bar or dealer.

Unattended-to Phase One issues: If you haven’t worked Steps One, Two, or Three, if you never got a sponsor (or don’t really confide in the one you have), if you haven’t dealt with other basic issues of early recovery, then your recovery has a weak foundation.

Unresolved Phase Two issues: If problems in your relationships, your work, or other aspects of your life still have not been adequately faced and resolved, they will make negative feelings simmer and eventually come to a boil.

Renewing old friendships: Once recovery seems well established, it may seem silly or over-cautious not to see an old friend you used to drink or use with. But unless and until that person is in recovery too, you are in permanent danger of picking up where your relationship left off.

Getting back on the old merry-go-round: As recovery progresses, feelings of invulnerability are likely to recur: “I am doing great. Seeing some of my old playmates, visiting some of my old playgrounds, won’t bother me a bit”. But that’s like skydiving without a parachute; the odds are definitely not in your favor. If you find yourself invited to a party or other event that is important to attend, but that you suspect could be risky, take an AA ally along if possible.

Remembering the old days: Putting a shine on the bad old days (“Hey remember that time when we all got loaded and…?”) can make them suddenly seem like good old days. Don’t dwell on the past or you’ll dwell in it. Remember the bad effects alcohol or drugs had on you.

Indulging in doubtful habits: Nicotine and sugar have been associated with relapse in some people in recovery Other compulsive behaviors—gambling, sex, eating—may also weaken defenses against relapse.

Shifting the blame: If you can always find someone or something else to blame for your problems, past or present, you are not putting the responsibility for your life where it belongs: in your own lap.

Step 6: Processing the learning from the day
Duration: 20 minutes
Suggest that the group may wish to spend sometime looking back through the activities that they may have participated in during the day. They may wish to work individually, in pairs or in small groups to reflect on the learning from the day.

Ask for any reflections, and then thank the group for their participation and hard work throughout the day.
DAY 9

Session 15 Situations that invite relapse: (1 hr and 30 minutes)

Step 1: Ask participants to break into 4 groups and discuss the following questions (30 minutes)

Q. 1. What kind of situations do you think can invite relapse?
Q. 2. During telephone counseling, what do people give as a reason of their relapse?
Q. 3. What advise would you give to someone in recovery who has a lost a loving person?
Q. 4. Comment on being hungry angry, lonely and tired as possible causes to relapse.

Step 2: let participants present their findings in the plenary (Duration: 40 minutes)

Step 3: Lecture participants on Situations that invite relapse. (Duration: 20 minutes)

Facilitator's notes

Sometimes those in recovery don’t do anything specific to set themselves up for a relapse, but life itself sets them up. Certain situations, while not inevitably leading to relapse, do weaken one’s defenses. The only protection: eternal vigilance.

Bad times: Not surprisingly, many people relapse when something goes awry in their lives. Almost any major problem can trigger a slip, including the death of a spouse, child or other loved one; the loss of a job or anything.

Good times: While you might be alert to a possible slip when things go wrong, you are much less likely to be wary when everything is coming up daffodils—you inherit a substantial sum of money, you patch up your marriage, you get a great new job or promotion. “Staying sober is easy. I am doing great. I don’t have the problems others have. I am in control”. Gradually counseling sessions are canceled, better ways are found to spend evenings than going to AA meetings, and before you know it, you’ve slipped on a banana daiquiri.

Milestones: Being sober for thirty days, six months, one year, or five years is certainly something to celebrate. But it should also be a reminder: Keep working your programme. Unless it is also a time of caution and reflection, a recovery milestone can put recovery at risk.

Vacations: Pick and choose vacation destinations thoughtfully. Choose recovery-related retreats and conventions in early recovery, and later on stick to resorts and destinations that stress sobriety. When possible, share vacations with support group friends.

Change: Starting a new relationship or breaking up an old one, switching jobs, and moving all seem to increase the risk of relapse. So if you can avoid or postpone them, make no major changes until you are solidly in Phase Two, and even then be alert to the potential risk.

Boredom: Once the early work of recovery is completed and work and relationships are on an even keel, the addict may long wistfully for excitement—often for the wrong kind. If you crave
the rush that excitement brings, get the safe way: Remember that you can have fun without
drinking alcohol or taking drugs, many people do that.
Illness or physical ailments: Aches and pains—headaches, backaches, surgery, dental problems,
injuries, or other physical complaints—all have been linked to the start of drinking and drugging.
Not surprisingly they have been linked to relapse too. So if you experience frequent headaches,
testinal disturbances, muscular spasms, or any other symptoms, be alert for signposts warning
that you are speeding towards what might be called a medically prescribed relapse. Seek help
from a doctor who knows about your addiction.
Unexpected exposure: You are a nurse, and you find yourself with the key to the narcotics
 cabinet. You are doing the cleaning and you land on a bottle of beer you had hidden and
forgotten about. If you don’t have a plan for such eventualities, relapse is only a misstep away.
So be sure you plan ahead.
Triggers: Something you see (powdered sugar spilled on the table, a photogenic frosty mug of
beer in a TV commercial, the outfit you used to wear to wild parties), something you hear (rock
music you associate with shooting up, soul music that takes you back to your drinking days, the
music that you were listening to, the first time you smoked a joint), something you smell
(bourbon or stale beer, the perfume worn by the girl you used to do cocaine with, vanilla extract
when you are baking a cake, an acrid whiff of marijuana from the joint of a passer-by);
something you taste (nonalcoholic beer or wine, ice cream artificially flavored with rum);
something you touch (grains of sugar). Any of these could trigger a craving for alcohol or
drugs. Again, vigilance—being prepared for psychological ambushes—lessens the danger.

Session 16. Red Flags (Duration: 1hr and 30 minutes)

Step 1: Ask participants to break into 4 groups and discuss the following questions (30 minutes)
Q.1: Do you think that relapse just happens? Discuss.
Q.2: How do you think attitude and behavior contribute to relapse?
Q.3: Do you think denial can be a red flag to relapse? Explain.
Q.4: Do you think irresponsibility can contribute to relapse? Explain.

Step 2: Let participants present their findings in a plenary. (Duration: 40 minutes)
Step 3: Lecture participants on Red Flags.
Duration: 20 minutes

Relapse just does not happen. There is an early warning system built into recovery. If you are
always on the alert for its red flags—behaviors that quietly (or noisily) signal that a relapse may
be imminent—you can head off a slip before it happens. If any of the following are suddenly
part of your life, then take the preventative action.

Elaborate excuse making: When you find yourself going to great creative lengths to rationalize
or explain away your behavior—why you missed a couple of meetings, why you were late for
dinner. You are probably tottering on the brink.
Panic in the streets: Or anywhere else. Anxiety or panic attacks, thoughts of suicide, compulsive behaviors (gambling, promiscuous sex, and eating peculiarities are sure signs that your life is getting out of hand. They require immediate attention.

Irresponsibility: You start avoiding your commitments, failing to do what must be done.

Breaking the rules: The rules laid out for aftercare no longer seem to apply to you. You don’t see a need to promptly make amends when you make mistakes. You stop taking inventory.

Lying low: You used to check in with your sponsor a couple of times a week. Suddenly you realize it is more than two weeks.

Sick thinking: How can you tell your thinking is running a fever? While sipping a soda, you ponder the possibility of an innocent little “scientific experiment” in social drinking. You feel sorry for yourself. You start to dial your sponsor when temptation invades your mind; you abruptly hang up. You act on impulse rather than with forethought.

Strapping on spare parachutes: You turn down a ride to a meeting with an AA friend because you know you can’t stop for a drink with him “just in case” you need one. When an old drugging buddy calls to ask, “What’s happening?” you reply vaguely rather than with a clear firm “I’m finished with drinking and drugging. I’ve joined AA”.

Treading water: You follow your programme faithfully, but things are not getting better day to day, month to month. If this lack of progress continues for six months to a year, it’s time to think about seeking professional help, even if you have had treatment.

Going to hell with yourself: You find yourself forgetting to take a bath, roll on the deodorant, brush your teeth before you slip into bed, get your hair cut, wash your clothes, see the doctor when you are ill. The next thing you’re likely to forget is your sobriety. Keep an eye open for deteriorating personal hygiene. A deteriorating recovery programme often lies behind it.

Switching poisons: Alcohol is your nemesis, so what could be wrong with smoking a joint or two? You are a cocaine addict who never had trouble with alcohol, so why not switch to harmless social drinking? Or tranquilizers were your downfall, so why should a short snort be a problem? Keep away from everything: Remember you are an addict.

Denial: If any of the above describes your behavior, yet you insist, you are not at risk for relapse: Your denial could be taking the form of refusing to believe that, now that you are sober, you have an alcoholism/ addiction at all. Or you may be denying other problems—health problems, financial problems, relationship problems, and work problems. Continued denial of reality could lead to giving up on recovery and trying to escape your problems in an old familiar way: Through substance abuse. The only way to “escape” problems is to face them head-on and just plain wrestle them into submission.

Step 4. Processing the learning of the day (30 minutes)
DAY 10

Session Heading off a relapse (3 hours and 30 minutes)

Step 1: Ask participants to break into 4 groups and discuss the following questions:-
Duration: 40 minutes

Q. 1: How can someone guard against relapse?
Q. 2: "Before you pick a drink, pick a phone". Comment on the statement.
Q. 3: What do you think is the role of a counselor for someone about to relapse? Give all the details.
Q. 4: Do think prayer is a useful tool in guarding against relapse? If so how?

Step 2: Let participants present their findings in a plenary. (Duration: 20 minutes)

Step 3: Lecture participants on Heading off a Relapse (Duration 40 minutes)

If you notice any of the mentioned red flags (or any like them) waving in front of your face, try
any or all of the following suggestions to avoid falling off the wagon and under its wheels.
Remember, the compulsion to drink or drug will pass, if you do something else.

Call your sponsor (or counselor or addiction specialist) immediately: Here is where that list of
emergency numbers in your purse or wallet comes in. If you fail to contact the first person you
call, work your way down the list until you do reach someone.
Go to a meeting: If your usual meeting is not on, go to the one that is across town or if necessary,
in another town. Make no excuse. Spare no expense. Do whatever it takes to get you there.
Increase the number of meetings you have been going to: You may have to do a meeting a day
for several days or weeks.
Put mileage between yourself and temptation: Walk out of a party or other event the moment you
begin to sense “that old feeling” coming on. Say no to the “friend” urging you to have “just one”.
Try relaxation techniques, meditation, and prayer, reading the Big Book.
Sign up immediately for a recovery weekend or retreat: Total immersion in convivial, sharing,
understanding atmosphere for forty-eight hours can be a very sobering experience.
Remember what pre- sobriety was really like: Now is the time to pull out that cache of rub-your-
nose-in-it materials you prepared in early recovery (the history, letters, photos, videos, etc.) so
that you don’t forget to remember all gory details. Ask yourself what it is you want to get out of
the drink or drug that is tempting you, and whether there might be a better way to reach that goal.
Also think about the long-term effects of that drink or drug on you and those you love most.
Always be prepared: Know what you would do in a whole list of perilous “if” situations: if you
suddenly discover a bottle of liquor you buried long ago under a pile of sweaters in the cedar
closet. Know not just roughly what you would do, but precisely, including the very words you
would use.
If you feel a slip is close and fear you’ll fail the challenge, consider giving yourself a “booster” at a weekend retreat, refresher programme: Signing in before you actually have a slip, you skip the detox portion of the treatment and move directly to dealing with your mental state—which is where the problem is, any way.

If you spot a pattern of regular slips, or a cycle of periodic sobriety followed by slips, try to head them off: If, for example, you seem to relapse every six months or so, check in for a booster after four or five months.

Strengthen your recovery: Thoughtfully and honestly evaluate your recovery programme to expose the weaknesses that keep you tottering on the brink of relapse.

**Session 18. If you do slip and eventually relapse:** *(Duration: 1 hr. and 30 minutes)*

Step 1: Ask participants to break into 4 groups and discuss the following questions *(30 minutes)*

Q. 1: What advise would you give to someone who has had a slip?
Q. 2: What advise would you give to someone who has relapsed?
Q. 3. Do you think someone in relapse should hospitalized? Why?
Q. 4. What do you think is the role of treatment centres in recovery?

Step 2: Let participants present their findings in a plenary *(30 minutes)*

Step 3: Lecture participants what should be done for someone who slips or relapses *(30 minutes)*

First of all, remember that one slip (taking that first drink or fix) does not make an irreversible relapse. A close call or an actual relapse doesn’t mean you are a failure, just that your recovery programme needs immediate first aid. The following steps can turn a slip into a learning experience—one that DAY 1e, instead of damaging your recovery, will strengthen it.

**Facilitator's Notes**

Recognize that you made a mistake: But that you don’t have to compound it. One drink does not deserve another.

Don’t surrender to the “Now that I’ve had one, what difference will a few more make?” despair: The difference could be considerable—between being sober this time next year and being dead.

Leave the scene of the crime without a moment’s hesitation: If you are at home, dump the drug or alcohol down the toilet before you go, or it will be awaiting you on your return. Your destination should be an AA meeting, your sponsor’s home, the home of another friend, your counselor’s or doctor’s office, or some safe haven.

Get immediate help—from your counselor, your doctor, your treatment programme, your sponsor, or whomever you feel would be most useful in directing you back to the road of recovery: Pick up the nearest telephone and start calling up your list, keep trying until you reach someone.
No relapse just happens. Once the crisis is over, do an inventory to try to determine why you slipped: Look over the risky attitudes, behaviors, and situations described in the preceding pages, and see which may have been responsible for your fall. Were there physical cues—sights, smells, sounds, and tastes—that triggered your action?

Reinforce your recovery programme as though you were starting from scratch in Phase one: go to more meetings, rework the twelve steps.

Consider a treatment booster shot—in—or outpatient.

Assure yourself that you can succeed. You can.

If at any time in recovery you return to your drinking or drugging behavior, even only sporadically, you are in relapse. Taking the appropriate action is critical to your survival:

- Get short-term help: Don’t think about it, do it. As soon as you can pull yourself together to make a phone call, call your counselor, sponsor, doctor, treatment programme, or another strong, reliable AA person.
- Detoxify: If you experienced withdrawal the first time you quit, you are likely to again, even after just a small dose of alcohol or another drug. Since withdrawal symptoms are generally more severe the second time (or subsequent times) around, you may require medical detox. A few days of hospitalization by your family doctor may be all you need.
- Get long-term help: If you didn’t go the formal treatment route the first time round, now is good time to try it. If you did, but lacked motivation the first time, professional treatment may be particularly valuable now. If you really open up your mind, all the words you listened to but didn’t make a part of your life then should now finally make sense.
- Spotlight your shortcomings: You didn’t relapse accidentally, unless a friend with a distorted sense of humor sneaked some booze hash into your beef goulash. (What were you doing associating with anyone who could think that was funny anyway?). The newly sober recognize that they have a lot to learn about recovery. But relapses sometimes feel that they are experts on recovery, that the relapse was “just fluke”.
- If you want to get sober again—this time for good—the first thing you’re going to have to admit is that what you know about recovery couldn’t fill a shot glass. Then start your programme over from scratch, soul-searching for the chinks in your recovery armor that made it possible for drugs or alcohol to seep through. You can go to your old AA group or a new one.
- Re-focus on recovery: Eventually what you learn from your relapse will allow carrying a powerful message to others. Right now you have to forget about being a sponsor or helping other people, and instead look after number one. Even if you have been sober for years, a relapse means you have to drop everything and concentrate on the work of recovery—on Phase one (Steps 1,2,3 and 4) work. You will probably complete it in less time than you did the first time around, but you need to “get it” better than you did then.
- Making meetings mandatory: Don’t ever let going to Twelve-step meetings become a random activity, structure you life so that meetings are a routine part of it.
- Unmask the villains: Carefully examine your current involvement in AA (do you have and regularly confer with a sponsor? Have you gotten careless and cavalier about attending meetings? Do you read the big book and other literature often?) and your life (are your
relationships healthy, is your job interesting and on track, is there too much stress, too little fun in your life, too few friends?)

Don’t be embarrassed: Your friends at AA know that nobody’s is perfect and are probably thinking, “There but for the grace of God go I”. You may feel uncomfortable having to start all over again, and may even have to take some ribbing at AA; but mostly you will get a lot of loving support.

Think positive: Anyone can become successfully clean and sober—anyone who is motivated and willing to put in the necessary hard work. This time, anyone can be you.

Step 4. Process the learning of the day. (30 minutes)

DAY 11

SESSION 19. Codependence(y) I (Duration: 3 hours)

Objectives:
To offer participants an opportunity to:
- Define codependence(y)
- Differentiate between "Codependence" and "Dependency"
- Learn about codependent families and how to identify them and be able to assist significant others
- Identify issues/Denial patterns among codependent personalities

Methodology:

Step 1: Ask participants to break into groups and discuss the following questions:- (50 minutes)
Q.1. What do you understand by codependency? Definition and description.
Q.2. What do people who come from families suffering from alcoholism go through?
Q.3. Distinguish between "codependency" and "Dependency". What are the common characteristics of dependent personalities?
Q.4. Suggest ways you think could be applied to manage codependent people.

Step 2. Let partipants report back their findings in a plenary (40 minutes)

Step 3. Then using a power point projector / flip chart, give a Lecture on "Codependence"(y)/ "Dependency" - (60 minutes)

Step 4: Processing the learning of the day (Duration: 30 minutes)
Notes on Codependence: (Hard copy to be passed on)

Definition:
The unconscious belief that you are responsible for and can create the happiness, satisfaction and well-being of others. Even to do so at the cost of your own happiness, satisfaction and well being.

Codependence characteristics
Caretaking, Low self-worth, Repression, Obsession, Controlling, Denial, Dependency, Poor communication, Weak boundaries, Lack of Trust, Anger, Sex problems (others)

Progression of the diseases
In the later stages of codependent individuals tend to:
- Feel lethargic
- Feel depressed
- Become withdrawn and isolated
- Experience a complete loss of daily routine and structures
- Abuse or neglect their children and other responsibilities
- Feel hopeless
- Begin to plan their escape from a relationship they feel trapped in
- Think about suicide
- Become violent
- Become seriously emotionally, mentally or physically ill
- Experience an eating disorders…….over or under eating
- Become addicted to " Alcohol or other Drugs"

The three unwritten rules in an alcoholic household
1. don’t talk
2. don’t trust
3. don’t feel

Family Roles in a Dysfunctional Family
When one member of family is chemically dependent, whether on drugs or alcohol (either an adult or child, the other members of the family assume roles, usually subconsciously.

These roles seem to enable the family to protect itself and the individual members from the downward spiral that chemical dependency causes. Unfortunately, these roles actually cause the family additional harm because they put off the confrontation that is the first step in the recovery of the chemically dependent member.
The five basic roles are not static. A small family may have more than one role for each person and a large family may have more that one person playing a single role. Which role is played by which person is more related to his or her position in the family than to personality factors.

(Facilitator explains the following)
- The family enabler
- The Hero
- The scapegoat
- The lost child
- The mascot

Its not only the codependent person or child that needs help but the whole family must be helped if they are to survive as a family and individuals in their later lives.

Day 12

SESSION 20. Effective management and treatment of codependence (y)

Duration : 3:10 hours

Objectives:
- To offer participants an opportunity to:
  - Enhance their knowledge in managing the codependent problems and the healing process.
  - Learn about Alanon Family and children of alcoholics as support systems
  - Learn about Referrals

Methodology

Step 1: Facilitator welcomes back the participants, and asks participants to make recap of the previous day (20 minutes)
Step 2: Using a projector Introduces and informs them of the continuation of the previous topic "Codependency" (Duration: 20 minutes)
Step 3: Participants break into groups to share their knowledge on management of codependency ready to report back to plenary (Duration: 40 Minutes)
Step 4: Participants report back to plenary session (Duration 20 minutes)
Step 5: Facilitator presents a codependent family case study (10 minutes)
Step 6: Facilitator gives a short lecture on Management of codependency (30 minutes)
Participants react to the case study (Duration: 30 minutes)
Step 8: Processing the learning of the day. (Duration: 20 minutes)
Facilitator's Short notes on Alanon and children of Alcoholics

Children of alcoholics have characteristics seemingly common to those of codependents and this is due to having been brought up in alcoholic households. Parents are affected the same.

Some of the characteristics include:
- Isolation and fear of the people in the authority
- Seeking approval in their performance
- Fear of criticisms
- May become alcoholics or gain intimate relationships with them
- They are attracted by relationship weakness in other people
- They have overdeveloped sense of responsible and easily get concerned of other people
- They often feel guilty and easily give in to others
- They become addicted excitement
- They confuse love with pity and tend to love people they pity
- They have stuffed up feelings from traumatic childhoods and have lost the ability to feel or express their feelings (that is denial) it hurts so much

Hand out on "Children of alcoholics and Alanon families"

DAY 13

Session 21. Introduction to Alcoholics Anonymous (AA) - 3 hrs.30 minutes

Session 14.1: The History of Alcoholics Anonymous

Objective: To offer participants an opportunity to:
- To understand the origin of AA and its implications in the life of a recovering alcoholic
- To provide referral contacts for online alcohol counseling
- To process formation of support groups

Methodology

Step 1: Facilitator welcomes back participants and asks a volunteer to do a recap of day 12 (10 minutes)
Step 2: Ask participants to break into 4 groups and share knowledge on their AA experience. (30 minutes)
Step 3: Let participants report their findings in the plenary (Duration: 30 minutes)
Step 4: Facilitator explains the AA concept basing on participants' knowledge and contributions (40 minutes)
Step 5: Role play for an AA group and how it is formed: Facilitator involves the whole group and engages them into an AA session/ AA fellowship (60 minutes)

Step 6: Participants discuss and react to the Role play for an AA group (Duration: 30 minutes)

Step 7: Processing the learning of the day. (Duration: 20 minutes)

A pamphlets as handouts

DAY 14

SESSION 22. : Experiential training at National Care Centre (NACARE) (Duration: 3 hours 45 minutes )

Objective:
- To offer participants an opportunity to have a hands on experience with existing clients at the centre
- To enable participants access the available literature and materials at National care centre
- To Encourage reading culture for the counselors in order to enhance their knowledge base on alcohol issues

Methodology:
- Step 1: Three Participants Selected travel to visit National Care Centre accompanied by facilitator
- Step 2: Participants are introduced to staff and clients at NACARE (30 minutes)
- Step 3: Participants interact with clients and identify issues related to alcoholism (1 hour)
- Step 4: Participants join the Group Therapy session to learn motivation counseling and the group counseling process and discharge plan (1 hour)
- Step 5: Participants assigned clients to clerk for (one to one counseling) 45 minutes
- Step 6: Participant access and review the current literature on alcohol and other addictive substances
- Step 7: Facilitator asks participants to record the summary of their findings ready to share with other participants in the training the following day.
- Step 8: Processing the learning of the day (Duration: 30 minutes)

NOTE: 2-3 Participants will be selected to visit National care centre at different intervals to avoid clients being overwhelmed and for participants to adequately achieve their objectives
DAY 15

SESSION 23: Sharing of experience at NACARE with fellow participants (2 hours)

Objective: To report and share their hands on learning experience with clients at NACARE

Methodology
Step 1: Participants discuss the experiential report of fellow participants (20 minutes)
Step 2: Processing report on their findings from the centre (20 minutes)
Step 2: Facilitator explains the activities involved in alcohol and substance abuse rehabilitation at National care Centre (40 minutes)
Step 3: Question and answer session (20 minutes)
Step 5: Participants Evaluate the session topic using a questionnaire given by facilitator (20 minutes)

SESSION 24. PATTERNS OF DRINKING (1 hour and 30 minutes)

OJECTIVES:
- Share knowledge on the different stages of drinking
- Understand the different patterns of drinking
- Distinguish between social drinking, binge, problem drinkers and real alcoholics

Methodology
Step 1: Allow questions and brainstorming on the patterns of drinking (10 minutes)
Step 2: Participants break into groups to discuss the patterns of drinking ready to report back into a plenary (40 hrs)
Step 3: Plenary: participants report back to plenary and share their findings (20 minutes)
Step 4: Facilitator gives a short lecture using a flip chart and displays images of alcoholics at different stages (20 minutes)
Step 4: Role play: Facilitator ask participants to role play on their pattern of drinking and how alcohol affects them (10 minutes)
Step 6: Participants Evaluate the session topic using a questionnaire given by facilitator (20 minutes)

Session 25: Smoking tobacco and other drugs

Objectives:
- Understand smoking as an addiction
- Introduce the adverse effects of tobacco use
Methodology

Step 1: Ask participants to say anything they know about smoking and capture the information on a flip chart.
Step 2: Then lecture participants on types of drugs smoked and the adverse effects and how to get rid of the problem of the addiction.
Step 3: Give handouts on smoking tobacco and other drugs.

Day 16

SESSION 26. Client motivation and team working to manage alcoholism (2 hours)

OBJECTIVES:
• To help participants gain best skills in interventions and client motivation for clients to attend counseling, and learn teamwork in counseling.
• To enable participants be able to tell what they see/hear on a client with honest and in a respectful manner.

Methodology
Step 1: General session: Facilitator asks one member to guide the motivation process in a class using creative jokes or ice breakers (10 minutes)
Step 2: Role play on motivation counseling and referral (10 Minutes)
Step 3: Facilitator asks participants to react to the role play and critic the role play (10 minutes)
Step 4: Facilitator gives a summary of motivation counseling and referral process (30 minutes)
Step 5: Facilitator introduces teamwork experience to manage alcoholics (40 minutes)
Step 6: Facilitator guides participants to get involve in a motivation and evaluation exercise using placards pinned on the back of each participant (10 minutes)
Step 7: Participants Evaluate the session topic using a questionnaire given by facilitator (10 minutes)

Session 27 The DO's and DONT's of online counseling (1: 10 minutes)

Objectives:
• To guide participants on client confidentiality
• To train participants in self management and improve on communication skills
• To help online counselors maintain relationships with their listeners
• To train participants in maintaining ethics and integrity of counseling
Methodology

Step 1: Facilitator gives a handout on ethics of credentialed alcohol counselor
Step 2: Using a flip chart, facilitator asks participants to share what they know about ethics in counseling, as writes them down (20 minutes)
Step 3: Brainstorming, Question and answer session (20 minutes)
Step 4: Facilitator gives a brief lecture of the importance of ethics, especially during online counseling, using a flip chart (30 MINUTES)
Step 4: Hand out on other ethics in counseling

FACILITATOR'S NOTES

Tell the participants to avoid closed questions, such as those designed to give a simple "yes" or "no". It is important that all counselors at any level need to practice the use of open ended questions, to encourage further conversation and sharing. Online counselors need to maintain and keep the questions clear and simple. Avoid asking questions that are offensive and make sure your suggestions or solutions are coincide.

Session 28. WAY FORWARD

Objectives:
To offer participants an opportunity to:
• Develop an action plan
• Discuss any outstanding issues
• Make a follow up on the call in clients

Action plan
Explain to the group that it is important to spend time reflecting on the learning from the workshop, and begin to develop an action plan for future hotline counseling. The action plan should be “SMART” (Specific, Measurable, Attainable, Realistic, Time bound). Suggest that they may travel to the villages where the callers are located and be able to assist them in forming AA groups.
Ask them to focus on some of the following questions:
What do I need to do as a result of this workshop?
Who do I need to contact?
What to sort of feedback do I need to give and to whom?
When do I need to do this?
Where do I do it
How do I feel about starting Alcoholics Anonymous groups in the future?
What aspects of my role as a counselor do I need to work at?
How will I do this?
How will I keep in contact with others in order to develop our knowledge together?
How can I work with other to maintain the client profile
What else do I need to know or do?
How will I find out?
Anything else?

Outstanding issues

There may be some issues that the participants still wish to discuss prior to leaving the workshop. Some of these may have been written down at the end of 10.1 above. Other issues may have occurred to some individuals during the previous sessions. Explain that this is an opportunity to discuss these, you may wish to divide the participants into “focus” groups to discuss some of the issues, or may hold a large grouped discussion if the issue affects most in the group.

Session 29.: Evaluation

• Evaluation
• Closing activity

Objectives:

• To offer participants an opportunity to:
• Comment on the workshop experience
• Say “Goodbye” to each other.

Evaluation

Ask the participants to work in pairs, or small groups to reflect on the workshop, using some of the following questions:

• What have been the most enjoyable aspects of the workshop?
• What have been the most important aspects of learning?
• How do you feel about alcoholism/substance abuse?
• What are your thoughts about improving hotline counseling using 12 steps?
• What will you tell others about your experience in the workshop?
• Anything else?
Allow 15-20 minutes for this. Suggest that participants may also want to use some of the time for a final look through the handouts.

**Closing activity**
The facilitator may decide upon a suitable activity, or they may use this:

Explain to the group that they are now in the final stage of Tuck man’s “group life” i.e. the stage of “mourning” or “ending”. It is important to have the opportunity to say “goodbye” and appreciate each other for the full time participation and support. This allows everyone the chance to give others their own personal “comments and hugs if so desired. Thank everyone for their participation in the workshop, and wish them luck as they progress with online counseling. Ask them to stand up, move around the room and hug their own friends whomsoever they choose, and close.

*The End*