Alcohol, medicaments, illegal drugs, nicotine, and addicted behaviour

An offer to all,

who are trying to help a loved-one.

DHS

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About this brochure

Is alcohol consumption or the consumption of other drugs, e.g. medicaments, causing problems in your partnership? Do you know, or suspect, that a person to whom you feel close is using an addictive substance to try to get through everyday life or to escape from it? If so, this brochure has an offer for you.

Helping is not easy

To help another person, to extend comfort, encouragement or support, is not easy. It requires chiefly – apart from knowledge, good will, and energy – understanding for the other person's situation. Especially when that person is risking addiction, or actually is addicted, in terms of dependence on alcohol, medicaments, illegal drugs, or nicotine. Also, certain patterns of behaviour can (seemingly) become indispensable – examples are playing gaming machines or various kinds of eating disturbances.

Trying to help is a battle ...

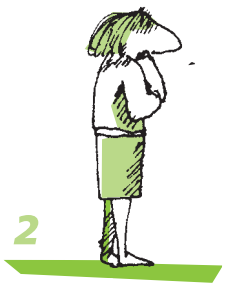
Anyone bent on taking active steps to wean another person away from addicted behaviour, or a particular addictive substance, will necessarily be looked on as an enemy. The would-be helper is trying to take away from the other what he thinks, more than anything else, he needs to get through life. This turns all attempts to help into a constant battle. On the heels of requests, appeals and threats follow offence, promises and disappointments.

... all help becomes a fig leaf

On the other hand, family members often do their best to cover up the fact of addiction. They make excuses for the addicted person with his/her boss, relatives and friends, or pay off debts incurred as a result of addicted behaviour. This turns help into a fig leaf. What is done with the best of intentions turns into its opposite. Because it helps the dependent person to live with his addiction, not get rid of it.

Destination helplessness

Efforts that lead nowhere and battles over the addictive substance are – almost always – typical of how addicts relate to would-be helpers. A sense of helplessness on both sides is often the result. Addicts see themselves as helpless in the grip of their drug. They are incapable of actively shaping their lives. Family members are now at the end of their wits and lose all hope. It doesn't have to end like this. Though family members cannot directly influence how an addict behaves, they can assist in getting him/her to accept help and make a recovery.



The meaning of addiction

Only by grasping what it means to be addicted can you understand why your battles over the drug are unsuccessful; only in this way can you regain some of your composure. Therefore, Part One of this brochure provides some information on what this disease called addiction is. The chief aim here is to give you some insight into the modes of behaviour and experience that characterize dealings between addicted persons and family members; as well as into the nature of addiction and the loss of freedom it brings. At the centre of the brochure you will find a colour supplement containing, among other things, brief pointers on the effects and risks of the key legal and illegal drugs.

A different way to help

Part Two describes a path called 'helping by not helping'. This approach is completely different from what we all normally understand by help or helping. Perhaps for this reason you may think, at first, it makes no sense at all. Please let our explanations sink in; take time to think them over.

You are not alone

Addiction is not an isolated fate. On the contrary, for years now it has been the number one social/medical problem in Germany. Millions of people are affected. They and those closest to them need help, and they find this in remedial centres for addicts. In Part Three, counseling centres, self-help organizations and abstinence-promoting associations all offer their help. For you to find the courage to take up these offers of help is the aim of this brochure.

The meaning of addiction

The road to addiction

Why do people become addicted? So far no one has succeeded in answering this question in any generally valid way. The addictive personality, the addictive family and the single cause auf addiction do not exist. What we invariably have is a whole series of factors that act together in a process of evolving addiction, mostly lasting several years. Just why somebody has become addicted – this can only be finally answered by taking a very close look at the individual life story of the afflicted person.

An example: people who have not learned how to express their emotions openly may be tempted to drown out their unwelcome feelings through drug abuse. Likewise, troubled social and family situations, like having no job, being parted from loved ones, or the monotony of everyday life, can form a slippery slope into abuse and addiction. Other addicts were the victims of traumatic childhood experiences like sexual molestation and other forms of violence, which they were unable to come to terms with. Peer pressure, thoughtlessness, and a hunger for new experiences represent the other side of the story.

At first, reaching out for what will become the object of addiction is a great success: depending on how the particular substance takes effect (and on one's personal makeup) one feels relieved and unburdened; for the first time in ages one feels really relaxed, "on top of the world", really belonging. Everyday life recedes. Perhaps one has feelings and moods beyond one's wildest dreams. Whatever else, one feels better than before.

Once one has learned to steer one's moods and feelings by resorting to the (future) object of addiction, the temptation to do so becomes ever more frequent. The positive effect peters out ever more quickly as time goes by, and one's ability to react appropriately to one's personal difficulties dwindles. One's underlying psychological weakness grows ever greater. This is joined by a stale feeling of behaving wrongly. The desire to consume the substance has, by now, grown so strong that it is abused more and more frequently and for completely different "reasons" – at first still in the vain hope of achieving a sense of well-being. Ultimately, the attempt to achieve a better result by taking more and more of the harmful substance ends in disaster.

Psychological addiction

What we now have is addiction. The addictive substance becomes the focus of all actions, thoughts, and feelings. As time goes by, the only thing that matters is to avoid the deep sense of unease that comes from being deprived of the substance. The addiction has drowned out the original problems and created new ones.

Physical addiction

Apart from psychological addiction, physical addiction is also caused by alcohol, nicotine, various medicaments, and heroin: the body reacts to the constant intake of the addictive substance by adjusting its metabolism. If the addictive substance is then abruptly withdrawn, this leads – depending on the substance – to withdrawal symptoms, ranging from unpleasantness to pain or even loss of life, all of which rapidly recede upon renewed intake of the addictive substance.

Psychological addiction, on the other hand, is often outwardly inconspicuous and hard to detect. But precisely this makes it all the more difficult to grapple with and resolve. It is the main reason why addicted persons repeatedly fall back into their old ways, even after they have gone without the drug for days, weeks or sometimes even years.

Addiction - an ailment in need of treatment ...

Without expert help from social workers, psychologists and physicians, addicts are usually not able to throw off their addiction. Comprehensive information on therapeutic programmes and other offers of help, as well as the financial specifics, can be obtained from physicians and sickness funds (and from the counseling centres set out in detail from page 25 on).

... and active engagement

But addicted behaviour is not only an ailment in need of treatment; it also requires the addicted person to become active, implying, as it does, an invariably futile attempt to solve one's own problems and achieve a sense of well-being. For the moment, this behaviour forms part of the problem. Nobody can – from the outside, as it were – make it go away. A cure is only possible when the addicted persons themselves develop a wish to lead a free (addiction-free) life again, and are ready actively to work towards this goal.

Fear of being helped

Whereas with physical sicknesses most people are willing to accept help from experts, with many psychological disorders this is not the case. Addicts conceal their disorder, as a rule, just as long as they can. They conceal it from others and from themselves, even when they already know, deep down, that they cannot keep on like this. They feel guilty about the condition they are in, and are ashamed of their apparent lack of will. Another factor is that they know exactly that any help invariably means weaning oneself off the addictive substance, and their fear of falling into a deep hole overwhelms them. Considering just how long the addicted behaviour has served as a reaction to a great variety of moods, experiences, and needs, and just how many new patterns of behaviour and attitudes must replace the old ones as the cure proceeds, this fear is readily understandable.
Addicts often overcome these obstacles only under extreme outside pressure, such as losing their job, expulsion from school, financial difficulties, or separation from their family. Only when they suffer more from the consequences of their addiction than they gain in terms of pleasure or comfort can they admit the reality of their situation and muster the will to do something about it.

Addiction has many faces ...

Perhaps you are wondering why this brochure mentions in one breath alcohol and illegal drugs, medicaments, nicotine, gambling and eating. Can the woman who regularly takes two sleeping pills before going to bed really be compared with teenagers who smoke hashish or marihuana and increasingly lose interest in school or post-school education? And what are we to say about the man who drinks several bottles of beer a day, followed by a couple of shots of hard liquor, just to help him handle the pressures of work and to induce relaxation?

In fact, dependencies on the various addictive substances differ quite considerably in many respects:

→ ***In their conspicuousness and social acceptance***
While those addicted to legal drugs can consume, obtain, and store their preferred substance, within certain limits, in a socially unobtrusive, indeed accepted manner, consumers of illegal drugs, right at the beginning of their "drug career", run up against the law and come into contact with a very distinctive subculture.

→ ***In their potency***
Addictive substances all possess a substance-specific "binding force", which – allowing for personal fluctuations – determines the strength of the addiction. Thus the binding force of Aspirin is less than that of Valium, and that of Valium, in turn, is less than that of heroin.

→ ***In the speed of their formation***
Alcohol addiction, for example, often only develops after many years of use, while addiction to heroin happens almost instantaneously.
Moreover, the risk and gravity of the ensuing damage varies from substance to substance (see colour supplement).

...but only one reality

However, all addicts are alike in one essential respect: they are not free. They have lost their freedom to their preferred drug. They deny and cover up their habit, become (seemingly) unpredictable, and disappoint and deceive those they work and live with.

Co-dependence

Also the fears and worries of family members, caught as they are between hope and despair, are all very much alike. Despite individual differences, there is so much shared ground in the reactions and experiences of family members that a special term has been coined to describe the condition: "co-dependence". This also refers to the previously mentioned (and thoroughly undesirable) feedback effect of co-dependence: it bolsters and promotes the dependence of the addict.

Addictive substances are – almost – interchangeable

Many addicts practice abuse not only with their drug of choice but with other drugs too (multiple abuse). This is often done to bridge gaps in the supply line. Alcoholics often make abusive use of e.g. barbiturates, since their effects closely resemble those of alcohol. Sometimes persistent multiple abuse results in addiction to yet another drug (multiple dependence).
Another syndrome worth mentioning in this connection is that detoxification and being weaned off the original drug may succeed, but without the inclination to addicted behaviour being really overcome. For instance, former heroin addicts (now abstinent) may develop massive eating disorders. Also, excessive caffeine and nicotine consumption can be signs of renunciation of another drug not yet fully achieved.

A fruitless struggle

Being dependent means, above all, not being free. Those in the grip of a dependence cannot keep promises or stick to what they have resolved. Disappointments are therefore unavoidable.

Addicts conceal their condition from themselves and from others. In part from fear of withdrawal symptoms, in part to preserve a vestige of respect and self-respect. Every attempt to force an addict to grasp his predicament and to bring home to him his dependence, e.g. by making an exact list of his daily intake of medicaments, is taken as an attack on his person, calling for every effort of resistance.

If you bear in mind these inter-linkages, you will be able to relate to your addicted family member with greater composure. Grievances and disappointments will be less devastating. You can then accept more readily that you will (indeed must) always lose out in the battle against the addictive substance.
The quarrels that typically result are not, however, without effect.

They are injurious to you, as they also are to the person you desire to help:

- ***Constant arguments destroy the trust on which the relationship is based.***
- ***They give the addicts a pretext to attempt to justify their own behaviour in terms of the other person's faults, at the same time repressing their own massive feelings of guilt and shame. "Attack is the best defence"!***
- ***Such "attacks" also supply a reason to seek comfort from their drug of choice again.***
- ***Since your thoughts constantly revolve around your relative's behaviour, the heights and depths he/she is going through also affect your sense of well-being. The result for you is a considerably reduced quality of life; you have now become co-dependent, along with your relative.***

A different kind of help

Addicted persons must themselves grasp the reality of their situation. If they are to be cured, they will need expert help. All attempts to directly influence their addicted behaviour, or simply to remove the addictive substance from their reach, are fruitless and constantly give rise to quarrels.

What you can do, however, is lay the groundwork for your relative accepting help and making a recovery. If this is to happen, you will need to find the will and courage to abandon the struggle over the addictive substance in favour of a completely different approach. You will have to overcome the manifold fears that keep you captive in your role and turn your back on two-way accusations and quarrels. This also means that you will no longer assume the tasks and responsibilities of the addicted person, i.e. that you will again expose him/her to the demands of everyday life.

How can not helping help?

It is the fact of providing constant support in coping with everyday life that helps addicts deny their disorder and hide behind the belief that they can still get through life, one way or another, i.e. things are not quite so bad after all. Addicts are, to a high degree, reliant on getting recognition from others. If their errors become visible, to the point of losing face in their social environment, they suffer greatly. This will force them to grasp the reality of their situation and either to bear the consequences of their addicted behaviour or to change it.

Two examples:

- ***So far, you have explained away your partner's unusual conduct – resulting from intake of stimulants – in terms of her excessive nervousness, her effervescent temperament, etc. If you now cease to do so, she will try and find her own explanations.***
- ***For fear of your partner/child losing their job, you have always made excuses so far for their absenteeism. If you now stop doing so, you give back to them the worry of how to keep their job.***

By (again) reverting to your own interests and turning your back on the vicious circle, movement is re-injected into your frozen relationship. The atmosphere will change for you. In the long run, you will notice that the life you lead is now more satisfying. This may bolster the addict's longing for change.

Not helping does not mean doing nothing

Frequently used in this connection is the saying "helping by not helping". Not helping does not, however, mean doing nothing. On the contrary, this new way of helping requires from you consistency and plenty of energy

It will be a process of change for you, in the course of which you will acquire a raft of new attitudes and new ways of behaving:

→ ***Stop resorting to denial***

You recognize your family member's dependence as a fact, and finally give up hoping that the whole thing is simply a nightmare that will vanish of its own accord

→ ***Recognize that the addicted person is sick***

You accept that your family member is not weak-willed or unloving, much less malicious. You no longer react by reproaching the addicted person with inevitable and constantly repeated disappointments and breaches of trust.

→ ***Overcome your own fears***

You overcome the fears that flood in from all sides and prevent you from adopting this new way of helping :
"If I don't help her any more, I'll seem heartless and harsh!"
"It will only make things worse! It'll be the end of him!"
"He'll lose his job."
"Our child will turn into a criminal / become a whore, if we quit footing the bill."
"Everybody will pick up on what's happening to my wife and they will gossip."
And so on and so forth!

→ ***Stop helping***

You no longer attend to things that are none of your business. You no longer try to cover up the disorder and its effects. Precisely this is what many people find very difficult to do; it requires plenty of courage, given one's fear of how relatives, friends, and neighbours may react.

→ ***Overcome feelings of guilt***

Family members of addicts are often plagued by feelings of guilt and self-reproach. This is especially the case with parents of drug-addicted children.
Maybe you have made mistakes in the past, and maybe you haven't. The thing to do now is to overcome your crippling feelings of guilt, to re-align your behaviour so as to give yourself and the addicted person(s) a new chance.

→ ***Shoulder responsibility for your own life***

You have concentrated – possibly for years – solely on your family member and his/her problems. In doing so, you have neglected your own interests. In your efforts to help, you have yourself become helpless. Often you have (secretly) held someone else responsible for the joylessness of your own life. Now you realize that this attitude is getting you nowhere. You begin once again to shape your own life, to steer it to greater fulfilment.

→ ***I'm not you, you're not me***

By (once more) taking responsibility for your own life, you can also return to your family member the responsibility for his/her own life. You no longer see in him/her a part of yourself for whose actions you are responsible, just as if they were your own actions.

→ ***Be consistent***

Do the things you say you will do, and stop threatening to do things you cannot or will not do. Make it clear that whatever you say you mean.

All changes in their family members' behaviour are deeply unsettling to addicts. Very often therefore they will attempt to push you back into your former behaviour, by creating special difficulties and threatening to move out or even kill themselves. It is also possible that they may attempt, by making new promises, to get family members to revert to their old roles.

Do not give up hope

If you bear in mind the difficulties mentioned and recall how often you have fallen back, against your resolutions, into your old behaviour, you will be alive to just how difficult it is to stop helping. But "helping by not helping" is the only promising behavioural alternative for the families of addicts.
Hopes of rapid success, however, will rarely be fulfilled. Notwithstanding, you do not need to abandon hope, nor should you; you should not be deflected from your chosen path. Psychological changes need time more than anything else. Finally, too, this path offers a way out not only for the person you are trying to help, but also for yourself.

Do you really want to help?

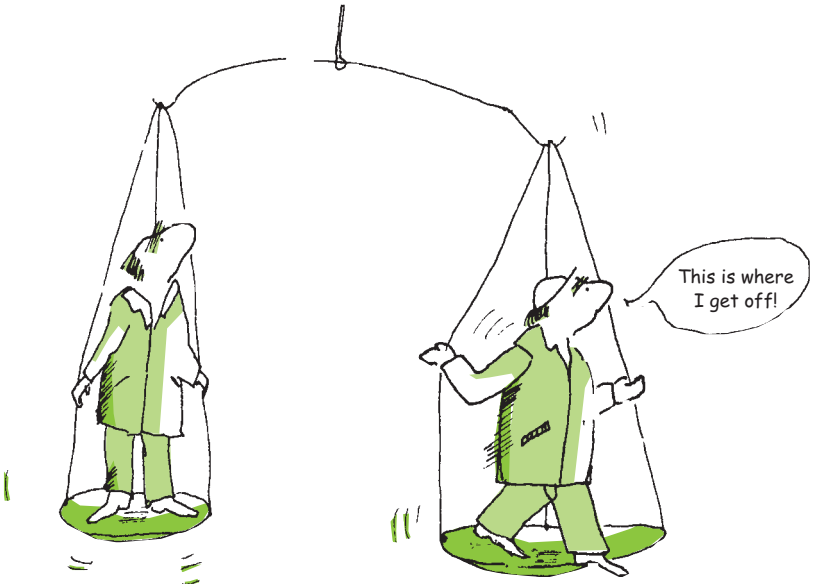
In the process described you will learn more about yourself. Do you still have enough strength and love to give your family member the time he/she needs to summon up the will to seek a cure? Are you still prepared to rebuild a life together? Or have you simply remained together from fear of separation or from a sense of duty? Well then, by the end of this process, you will be able to go ahead with the long-intended separation. In so doing, you may contribute more to the addict achieving insight and a cure than if you cling to a relationship going nowhere.

The first step

Nobody can decide overnight on new attitudes and ways of behaving. But these can be learned step by step.

Therefore as a first step – irrespective of how your partner or your child reacts – you should:

→ ***be willing to accept help!***



You are not alone

You don't have to tread the path of "helping by not helping" alone. Take the first step: contact a counseling centre, a self-help organization, or an abstinence-promoting association. There are large numbers of these bodies throughout Germany. Their task is to help addicts and their families. The lineup is diverse and manifold. There you can pick up detailed informative material and receive personal counseling and support in a one-to-one or in a group setting. Apart from groups in which addicts and their families jointly participate, special groups are also offered for family members.
Addresses and information about the help bodies in your local area can be found on pages 29, 30 and 31.

One-to-one interviews

In one-to-one interviews, which of course are treated as confidential, the focus is on you and your personal questions and worries. By being able to describe your situation, as it really is, to a knowledgeable and neutral person, you will be able – perhaps for the first time in years – to unburden yourself and find the distance you need to see your difficulties realistically. You will, so to speak, be taking a step back, the better to grasp the overall picture. An important point: you will be talking to someone who plays no role in your everyday life. You do not have to embellish the truth, and can rest assured that you are being taken seriously and understood.

You can reflect jointly, in such an interview setting, as to how you can behave appropriately to your addicted family member.

As a rule, the experts in the counseling centres can draw on years of experience in working with addicts, and can inform you about the various therapeutic programmes available, as well as the financing options. In case legal problems have arisen from the addiction in question, they will tell you of a suitable legal advisory body or legal practice. The counseling centres also know which physician in your local area has understanding and experience in treating addicts. If you are in financial difficulties, you will be informed of possible avenues of help. Questions as to how to deal with state authorities, your sickness fund, your employer and the like, can also be addressed in such an interview.

Group interviews

Counseling centres, self-help organizations, and abstinence-promoting associations also offer group interviews. These are mostly held once a week and last two or three hours. In these group evenings, you will meet people facing problems similar to yours. Just to know that other people are going through similar difficulties has a liberating effect and encourages openness. In many groups you will encounter participants who were once addicts, or family members of addicts, but who have succeeded in freeing themselves (or their family member) from addiction and who now lead a (drug)free and contented life. They will be able to give you hope. If you don't want to talk about your problems at first, you are perfectly welcome, as a first step, to just sit and listen and ask others to talk about their own experiences. In a group setting, you will sense directly that you are not alone. As the weeks go by, you will find yourself discussing what is on your mind, going over your behaviour again and again, and receiving encouragement. Here you will also be given the emotional support you need to overcome your feelings of guilt and shame. All this will help you to remain consistent and be patient with yourself and your addicted family member.

A new start...

If an addicted person can recognize his/her situation for what it is, and tries to get help, there is a real chance of him/her making a new start. Even so, throwing off addiction is a long-term process, one that doesn't end when physical and psychological withdrawal from the addictive substance has been accomplished. Step by step, new and satisfying avenues of how to spend one's leisure time, indeed one's whole life, must be found to fill the gap left by one's former addicted behaviour. Members of self-help groups who have long lived abstinently are able, time and again, to instill confidence in others that the frequently arduous path of seeking alternative behaviour patterns is worth taking.

...and something for all to work on

Addicts change as they draw nearer to being cured. They learn to recognize their personal difficulties and deal with them differently. In the process their relationship to family members also undergoes change. Making a new start, re-establishing a fruitful way of living together, is therefore a task for all parties. Family members, too, must learn new modes of give and take and correct their own errors. They must overcome their lack of trust and draw a line under the past.

It is not unlikely that family members during this period will be confronted by a series of feelings that shock them. Often they are wounded and jealous at the addict accepting help from "strangers", where they themselves struggled in vain for so long. Or else we feel ourselves downgraded at him/her now coming in for so much praise, while no one seems to remember our own efforts and how much we went through.

For these reasons it is important to actively involve family members in the healing process. Studies show that this also significantly increases the prospects of success. Active involvement of family members can take the form of family therapy, with addicts and their families jointly participating in therapy sessions. Another form is for all to take part in group interviews and self-help groups. If the addicted person opts for in-patient therapy, family members can prepare themselves in either group or one-to-one interviews for the time afterwards. Family members who so far have not contacted a counseling centre should do so now.

Yes but...

"Yes but..." you may be thinking. "I'm not really so sure that he/she is really addicted. How can I know?" This brochure has deliberately omitted a detailed description of what the symptoms of physical addiction are. Especially with the legal drugs (alcohol, medicaments, nicotine) the transition from use to abuse and then addiction is seamless. Addiction has many faces; psychological addiction especially can only be discerned with difficulty.

It is never too soon

Come to a counseling centre when you feel that a family member is behaving in an addicted way and using drugs, either legal or illegal, to help cope with everyday life or escape from its demands. Your thoughts, worries, and fears are reason enough to seek support. Maybe your family member is not addicted – yet. Perhaps you have not found the right words so far to address your fears and to alert him/her to a possible danger. Here too an interview with an expert will be of help.

This matter will be treated confidentially

Another obstacle to seeking help from a counseling centre may be the fear that the fact of addiction will become public, that the addicted person will be "exposed". Such fears are groundless. All information goes no further than the counseling centres. Nothing will be passed on to police, employers, or sickness funds. No outsiders will hear anything about the matters you raise. This also applies when the addicted person is consuming illegal drugs and/or engaging in drug-related crime to finance the addiction.

An act of betrayal?

Seeking out a counseling centre or self-help group does not mean that you have inwardly written off your family member, much less betrayed him/her. But it is not unlikely that you will be confronted with this very reproach, should you tell your addicted family member about what you are proposing to do. Please face up to the fact that you are truly in a difficult situation, one that has already cost you much energy and stifled your own joy in life. If you find yourself wishing for help, you certainly have a right to get it. Anyway, just allowing things to drift further is of no use to anyone; on the contrary, it is harmful to all concerned. Even though you hope that you might be able to scrape by as you have previously; though you hope the addicted person's behaviour will not get any worse; you must nevertheless face the question as to why you want to go on shouldering a burden which you could readily lay down and which additionally – in all probability – will only get heavier and not lighter over the years.

Turning to a counseling centre, self-help organization, or abstinence-promoting association is not a sign of giving up. On the contrary, it means that you have stopped waiting for a miracle to happen; now you are resolved to act, in order to induce a change for the better in the circumstances of life of both yourself and your loved one.

The counseling centre, self-help organization, or abstinence-promoting association are ready and waiting for your call.

Some terms – briefly explained

Addiction and dependence

The World Health Organization (WHO) has replaced the English term addiction by dependence. In German, however, it is still possible, and usual, to distinguish linguistically between *Abhängigkeit* and *Sucht*. *Abhängigkeit* chiefly refers to the pharmacological aspect of the phenomenon, while *Sucht* includes all psychological and social syndromes that accompany it or ensue.

A distinction is made between psychological and physical dependence. Psychological dependence is the uncontrollable urge to procure and consume the drug at whatever price, e.g. even through criminal activities or prostitution. The drug is consumed to achieve detachment, a sense of well-being or euphoria. Later, sometimes sooner rather than later, the only thing that matters is to cancel out the deep sense of unease and depression caused by deprivation. The effects of psychological dependence include exclusive focusing on the drug, plus a loss of interest in one's family, one's job or school; there is also a change in the friends one has ("drinking buddies", "people to hang out with"). Typical too is dissembling about the volume and frequency of drug intake; also, about the extent of their dependence as a further symptom of addiction (!), which, however, is not a character trait of the addict.

With physical dependence, the body reacts to the constant intake of toxins by reordering the metabolism. The excessive reordering that results from sudden deprivation of the addictive substance is responsible for the majority of withdrawal symptoms. These rapidly disappear with renewed intake of the substance.
A sign of approaching physical dependence is habituation, together with increasing tolerance and increased dosages. As a result of adaptive processes in the metabolism, otherwise deadly dosages can now be tolerated. To achieve the desired effect, addicts react by upping their intake.

Withdrawal syndrome

Physical signs of withdrawal are only evident with substances involving tolerance formation. These include, above all, the opiates (e.g. heroin), alcohol, barbiturate sleeping pills, plus many other palliatives and soporifics as well as anti-anxiety sedatives. These chiefly involve excessive reactions on the part of the vegetative nervous system (symptoms not restricted to the opiates): restlessness, dilated pupils, profuse sweating, irritableness, feeling cold, trembling, vertigo, fatigue, sleeping disorders, nausea; less commonly diarrhoea, vomiting and pains in the abdomen, the joints and limbs. Other signs are substance-specific complaints, e.g. convulsions in the case of barbiturate withdrawal.
Psychological signs of withdrawal are substance-craving, a compelling urge to renew drug consumption (which can be

overwhelming), restless states, a sense of driven-ness, irritableness, anxiety, depressive states ranging all the way to suicidal thoughts, sleeplessness, etc. In addition, there are other substance-specific symptoms, chief among which are psychological withdrawal symptoms, which impel addicts to consume their drug and keep them dependent against their deeper wishes.

Abstinence

Abstinence means completely renouncing the intake of drugs and other addictive substances. First, abstinence is a requisite for any drug therapy likely to be successful; and this must be maintained afterwards, since even the smallest dose of the substance – even after a long period of abstaining – can trigger off a severe relapse.

Alcoholics now living abstinently are commonly referred to as "off the booze"; drug addicts now living abstinently are said to be "clean". Abstinence can also express a whole attitude to life, as Alcoholics Anonymous does for former drinkers.

Withdrawal

The transition from addiction to a socially integrated, addiction-free lifestyle involves two phases: detoxification and dehabituation.

Detoxification is the physical withdrawal from the addictive substance. Such withdrawal normally happens abruptly; only in special cases will dosages be reduced slowly. Psychological support is indispensable; sometimes physical complaints will require medication. Detoxification normally involves hospitalization.

Dehabituation refers to psychological withdrawal. During dehabituation therapy, the causes of addiction should be uncovered and worked through. Some of the goals sought are: further maturing of personality, assuming responsibility, self-affirmation and psycho-social adaptation to the existing world with its realities and temptations as in a drug-free and well-balanced lifestyle, one that is also independent and productive. Dehabituation should take place, if at all possible, immediately after detoxification, otherwise a relapse is almost inevitable.

The duration of the detoxification phase can vary considerably. Sometimes, especially in cases of a persisting social ambience (family, attachment figure, workplace), six weeks may be enough, but usually it takes six months; with drug addicts, it often takes nine months or more.

Aftercare

The phase of dehabituation should, in turn, be followed as closely as possible by a period of intensive aftercare. This is an accompaniment to social (re-)adjustment and designed to reduce the risk of relapse to a minimum. Especially important in aftercare are self-help groups run by the ex-addicts and their families.

Addicted behaviour

Addicted behaviour is when people compulsively repeat the same actions, because they would like to repeat a satisfaction they have once experienced. Here it does not matter if the satisfaction sought involves the effect of a drug or experiences of some other kind. In this sense, even a certain type of non substance-linked behaviour may "degenerate into addiction".

There can be no doubt that addicted behaviour occurs among some gamblers or persons with eating disorders.

It is of interest to note that addicted ("pathological") gamblers, when deprived of their gambling outlets, may show symptoms not unlike the withdrawal syndrome of opiate addicts.

No exact definitions exist for the states found in "workaholics", "string pullers", "power freaks", "sex freaks", "couch potatoes", "computer game freaks" etc. One might argue as to whether these involve distinct addicted traits; it would be more accurate, however, to talk of compulsive behaviour.
Inability to act otherwise (repetition compulsion) or to stop (loss of control), loss of interest, denying or playing down one's condition while still wishing to overcome it, are all central features of addictions, including those not substance-linked. Without expert counseling, psychological therapy and social support or participation in a self-help group, many addicts are unable to break the habit.

Who can help with addictive or compulsive behaviour?

In many localities there are now self-help groups for those with gambling and excessive eating syndromes. Special clinics for eating disorders provide therapy. Treatment and counseling programmes are being expanded all the time. Psycho-social counseling centres; addiction counseling centres; marriage, family, and child-raising counseling centres (for addresses, see local phone books) are points of contact when you need help for yourself or members of your family.
Also many drug counseling centres have been focusing more strongly on addicted behaviour unrelated to addictive substances.
All centres listed on pp. 29-31, as well as

Gamblers Anonymous (GS), Interessengemeinschaft e.V., Eilbeker Weg 20, 22089 Hamburg, Tel: 040.2099009 or

Fachverband Glücksspielsucht e.V., Auf der Freiheit 25, 32052 Herford, Tel. 05221, Internet: www.glueckspielsuht.de and the

Bundesfachverband Essstörungen e.V., Pilotystraße 6 / Rückgebäude, 80538 München, Tel. 089.23684119, Internet: www.bundesfachverbandessstoerungen.de

will be glad to assist you in searching for the suitable help.

Alcohol

Alcohol and nicotine are the two most widely spread addictive toxins in our society. They are referred to as "stimulants" although it has long been proven that their consumption is, on balance, negative. Far more deaths result from excessive alcohol consumption and from smoking than from the so-called "drugs". The number of alcohol deaths in Germany each year is around 40,000.
Alcoholic beverages are available freely and in unlimited quantities in every supermarket, and even laws for the protection of young people offer limited protection here. The consumption of alcoholic beverages is socially accepted, along with excessive drinking and mild drunkenness. Only total drunkenness is usually rejected. Being able to drink without getting drunk, always a sign of alcohol habituation, and accordingly a preliminary stage to full dependence, is still seen by many as a "manly virtue". There is hardly an occasion or feeling that does not call for a drink. Alcohol is for most people a daily reality. Correspondingly widespread is its abuse. According to estimates by the DHS, the German Centre for Addiction Issues , in Germany there are approx. 1.6 million alcohol addicts in need of treatment in Germany, among whom there are twice as many men as women. The proportion of women has been growing constantly for years. Especially problematic is the growing number of young consumers of both sexes, for young people's nervous systems react much more sensitively to alcohol than do those of adults.

Alcohol

Alcohol

→ *Effects*

Socially desirable: *general sense of well-being, high spirits (euphoria), reduced anxiety, increased sociability*
Inebriation: *slowed-down reactions, reduced critical abilities, loss of inhibitions, foolish hilarity, in other cases an increasingly depressive mood, a narrowing of perspective, loss of speech and movement control (staggering, ataxia), loss of consciousness or alternatively deep sleep, sometimes aggressiveness, acts of violence (pathological inebriation)*

→ *Acute hazards of abuse*

Increased risk of accident, intoxication leading to death in states of deep unconsciousness due to cessation of breathing (apnoea)
Caution: *increasing interactions with numerous medicaments*

→ *Long-term effects*

Severe damage to the liver (women are at significantly greater risk), to the heart and the pancreas, inflamed nerves, impaired efficiency, depressions, skin alterations, premature aging, destruction of brain cells (starting with impaired memory, finally a fall-off in intelligence, diminished mental powers)

→ *Dependence*

Encroachment of severe psychological and physical dependence

Nicotine

Nicotine, like alcohol, differs in principle from other addictive substances only by the fact that it is deemed a "stimulant" and is socially accepted. Even more than alcohol, nicotine is available at all times and places. In 1990, in the former West Germany alone, there were more than 700,000 cigarette dispensers! In terms of its multiple effects, its importance in consumers' lives, and its range of possible deleterious effects, nicotine barely differs from the other addictive toxins. The results of a microcensus survey conducted in May 1992 showed that 28.8 percent of the German population over the age of 15 years were smokers. Here the percentage of male smokers is, at 36.8 percent, still significantly higher than in women (21.5 percent), although men are also particularly prominent in the trend towards non-smoking
According to figures from the World Health Organization, smoking is responsible for the premature deaths worldwide of approx. 3 million people each year. Especially detrimental are nicotine, tarry components, and carbon monoxide. Likewise the hazard from "passive smoking" has now been established. The image of smoking in public has radically altered owing to comprehensive publicity campaigns and other measures. Non-smoking is now considered socially desirable behaviour, and the interests of non-smokers are increasingly being considered, e.g. by smoking bans in public transport and buildings or by the creation of smoke-free zones in restaurants.

Nicotine

Nicotine

→ *Effects*

are based partly on nicotine, partly on psychological processes linked to the smoking process, these varying greatly from person to person
Subjective psychological effects: *calming, relaxing, stimulating when feeling down or worn out, promotes concentration, stills pangs of hunger, dissolves anxiety and tensions*
Physical: *constriction of blood vessels (cold skin, elevated blood pressure, increased heart rate, reduced flow of blood)*

→ *Acute risks of abuse*

Overdosing: *nausea, a feeling of weakness, profuse sweating, alternating bouts of high and low blood pressure, colicky abdominal pains; yet habituation develops as well as tolerance of nicotine*

→ *Long-term effects*

Impaired psychological and physical powers
• Constricted vessels lead to cardiac/circulatory damage, myocardial infarction, diminished blood flow especially in the legs, culminating tissue decay (smoker's leg), possibility of stroke, metabolic changes, diminished eyesight
• Damage to respiratory organs: chronic bronchitis (smoker's catarrh, smoker's cough), pulmonary emphysema, pulmonary/bronchial carcinoma (chief cause of death), larynx/oropharynx carcinoma

→ *Dependence*

Psychological, in some smokers progressing to full addiction; physical dependence does not require special treatment

Medicaments

Medicaments are synthetic or natural substances, with the help of which the characteristics, condition, or functionality of the human body, or mental states, can be healed in whole or in part. Their abuse has drastically increased in the last 15 years. Those compulsively and continually taking medicaments for psychological reasons are dependent. DHS estimates of the number of dependent persons in Germany requiring therapy run to some 1.4 million. Some two-thirds of them are women. To this must be added medicament abuse by alcoholics and drug addicts.
Often the substance that later becomes addictive is first encountered while undergoing medical treatment, the result being that its intake seems "legitimated", even when it continues to be taken without medical authorization. Medicament dependence (unobtrusive, rapid intake, without the reek of alcohol) is difficult to detect and often remains untreated for a long time. When new medicaments were introduced in the past, sufficient attention was not always paid to their addictive potential; through its aggressive sales and marketing strategies, the pharmaceutical industry has itself at times added to the incidence of abuse.

The abuse of laxatives and diuretics is causally implicated in eating disorders, as set out in the Addicted behaviour section.

Medicaments

Painkillers *(analgesics)*

This group includes the centrally-acting, extremely addictive opioids such as heroin, morphine, etc. (see following double page). Set out there are the risks of more peripherally acting painkillers, such as Aspirin and Paracetamol.

→ *Effects*
Alleviate pain, stimulate, generate pleasant bodily sensations

→ *Acute risks of abuse*
Impaired awareness, coordination disorders and risk of accident, in case of overdose: intoxication

→ *Long-term effects*
Increased doses, dulling of the mind, with long-term intake risk of "analgesics syndrome" with kidney damage as its most dangerous symptom

→ *Dependence*
Progressive psychological dependence; other agents (codeine, caffeine, etc.) in mixed preparations significantly boost addiction

Sedative and soporific medicaments *(sedatives and hypnotics)*

Chemically highly divergent group. Ranges from mildly sedative (e.g. valerian, hops) to long-acting strong soporifics (e.g. many barbiturates). The benzodiazepine-based soporifics are treated in the section dealing with relaxants and tranquilizers.

→ *Effects*
Sedate and induce euphoria, (in part) release from anxiety and tension ("care expeller"), stimulate initially, then cause good-natured, "hazy" inebriation in a semi-awake state, loss of balance (staggering) and speech impairment (slurring), sleep-inducing

→ *Acute risks of abuse*
Loss of coordination and retarded reaction times, risk of accident, forgetting that one has taken the first dose can easily lead to overdosing, therefore risk of intoxication, especially when alcohol or other medicaments are simultaneously taken; with barbiturates lethal outcome possible

→ *Long-term effects*
Similar to alcohol dependence, dulling of the mind, loss of interest, a state of permanent "fogginess" possible, decline in capacity to react and concentrate, mental deterioration, depressions and delusive states

→ *Dependence*
Heavy psychological dependence, with barbiturates and related substances also physical dependence including withdrawal symptoms (lethal outcome possible)

Relaxants and tranquilizers

These especially include the anxiety-neutralizing anxiolytics and tranquilizers from the group of benzodiazepine derivates such as Valium, Lexotanil, and many others, which are taken far too often against everyday stresses. In higher dosages these are used as soporifics (e.g. Rohypnol)

→ *Effects*
They act at certain attachment points (receptors) in the brain, exerting a dulling, anxiety-neutralizing, psychologically transporting yet simultaneously euphoria-inducing effect. Benzodiazepine derivates (BZD) are used in higher doses by drug addicts as bridging aids and by alcoholics as substitutes.

→ *Acute risks of abuse*
Proneness to accident as a result of impaired balance and motor control deterioration (ataxy), reciprocity when alcohol simultaneously consumed, intravenous intake hazardous to life when accompanied by opiate consumption (Rohypnol).

→ *Long-term effects*
Increased dosages not uncommon, but not required for onset of addiction (low-dosage dependence); at higher dosages mistakes of identification and aggressiveness may result

→ *Dependence*
Heavy psychological dependence, onset already possible after a few weeks of intake, also at normal therapeutic dosage

Stimulants and central-actina medicaments

Stimulant abuse is found in several pharmaceutical groups: amphetamines (analeptics), appetite depressants (anorectics), some blood pressure-raising medicaments (anti-hypotonics) and several other preparations containing the same agents, e.g. medicaments against colds and influenza.

→ *Effects*
Stimulate the central nervous system, boost motivation, initially performance too (which then falls off as a result of poor concentration), hyperactivity, boost the sex drive, tactlessness, self-aggrandizement, often lack of appetite. Withdrawal leads to paranoid ideas, at times delusive states, sudden collapse into a deep sleep lasting for hours or even days, long-term depressive post-states.

→ *Acute risks of abuse*
Aimless, at times self-endangering, hyperactivity, delusive states overshadowed by anxiety, sometimes with aggressive outlets, blood pressure crises (elevated blood pressure); overdosing may result in sudden death by cardiovascular failure.

→ *Long-term effects*
Increased dosages due to psychological habituation, stimulation phases give way to sleep and severe depressions (risk of suicide!), distrustful reactions, persecution mania ranging to fully-fledged, mostly short-lived psychoses (see also section on cocaine).

→ *Dependence*
Strong psychological dependence, risk of suicide upon withdrawal

Illegal drugs

Possessing and dealing in so-called "illegal drugs" is prohibited under German narcotics law; infringements are a criminal offence.
In Germany, according to DHS estimates, the number of those dependent on illegal drugs runs to some 120,000 in total. Around two-thirds are male. The proportion of adult as opposed to adolescent users has increased over recent years. The most commonly abused substances today are cannabis-based (hashish, marihuana) and heroin. Recent years have also seen a dramatic increase in cocaine abuse.

Added to the substance-linked hazards is a special collective hazard for the mostly adolescent consumers, namely the psychological and social risks that come with illegal consumption. Consumers have themselves stepped into criminality, thus inevitably coming into contact with a criminal milieu. In doing so, they become acquainted all too closely with a life of shoplifting, of prostitution, of the two-way "rip-off", and all of this often at a highly impressionable age.

Illegal drugs

Hashish and Marihuana (cannabis-based)

Hashish ("shit") is the resin of the hemp plant (Cannabis sativa), and marihuana ("grass") is its desiccated flowers, leaves, and small stems. All cannabis-based substances are usually smoked.

→ *Effects*
Differ greatly from person to person, mostly: general sense of well-being, high spirits, openness to new contacts, talkativeness, initial restlessness giving way to loss of motivation, sensory illusions, genuine hallucinations (rarely), altered spatial (more rarely also temporal) orientation, at higher doses mostly a sedative effect predominates.

→ *Acute risks of abuse*
Sensory illusions leading to inappropriate acts, risk of accident, bouts of fear and panic attacks ranging to "horror trips" (as with hallucinogens)

→ *Long-term effects*
Cancer of the respiratory tract and impairment of immune system likely, concentration and performance fall-off, reduced motivation to study ("dropout mindset"), loss of willpower, depressions, states of confusion, impaired psychological development, with intense abuse erosion of personality, in rare cases: triggering of psychoses, "flashbacks" (ECHO intoxication)

→ *Dependence*
Progressive psychological dependence, in rare cases demonstrable physical dependence

Hallucinogens

LSD is a synthetic product. Mescaline, psilocybine, ololiuqui are herbal agents that can also be manufactured synthetically. DOM or STP is a synthesis of a mescaline and an amphetamine component. When the hallucinogen's subjective effect no longer suffices, switching to other drugs is an attractive option. The effect of the drug can vary between 10 minutes and approx. 8 hours.

→ *Effects*
Varying with the substance, altered perception ranging from sensory illusions to full-fledged hallucinations, depersonalized feelings, mostly with slight euphoria, deceptive feeling of "expanded consciousness", not infrequently: bouts of fear ranging to "horror trips" and open panic; ECHO phenomena also possible at a much later time

→ *Acute risks of abuse*
Sensory illusions (not recognized as such) with inappropriate reactions, hallucinations with delusions of omnipotence, sometimes self-destructive acts like jumping from high-rise buildings in the erroneous belief that one can fly, "horror trips" can end in psychosis

→ *Long-term effects*
Intensive abuse causes addicts to turn away from the real world, encapsulation, exclusive devotion to esoteric matters, finally inability to act, apathy

→ *Dependence*
Psychological dependence

(opiates) Heroin

Heroin, a synthetic opioid (central-acting painkiller) was introduced as a putatively non-addictive substitute for morphium – in truth, however, it is stronger acting, stronger euphoria-inducing, and stronger dependence-furthering. The most important opioid in the drug milieu, favored by dealers; worldwide spread. Heroin is no longer legally available and can not be prescribed.

→ *Effects*
Acts on central nervous system, strongly euphoria-inducing, palliates anxiety and pain, instant orgiastic high spirits ("kick", "flash", "high") followed by a pleasant drowsiness ("nodding off") with an (unrealistic) sense of harmony with the world and a fading-away of all problems, ensuing negative fluctuation of mood (depression, restlessness)

→ *Acute risks of abuse*
Frequent death from overdose and toxic additives – loss of consciousness, respiratory paralysis, risk of infection (boils, hepatitis, AIDS), risk of accident from clouded consciousness and coordination disorders

→ *Long-term effects*
Increased dosages due to tolerance development, turning one's back on the real world ("hanging out" in the drug scene), erosion of personality, egocentric, irritable, aggressive, loss of all interest, drug-related crime, prostitution, destitution, delusions, brain damage, extreme loss of weight, sclerosis of the veins, physical decline

→ *Dependence*
Almost instantly manifested is extreme physical and psychological dependence

Cocaine

Cocaine is extracted from the leaves of the coca plant, a native of South America. It is traded as a white powder. Its high price and short-lived effect restrict consumption, but also provide an inducement to drug-related crime. Crack, a form of cocaine that can be smoked, has so far been rare in Germany.

→ *Effects*
Strongly stimulates the central nervous system, hyperactivity, euphoria, excessive need for new contacts, sexual arousal, loss of inhibitions, sense of omnipotence, sensory illusions; a positively experienced phase terminates in a sense of collapse.

→ *Acute risks of abuse*
Cardiovascular overload, death by respiratory arrest (apnoea) possible, faulty judgements involving paranoid reactions, irrational acts, hallucinations ranging to openly psychotic episodes

→ *Long-term effects*
A life torn between mistrust, deep depressions, despair, and manic-euphoric hyperactivity, coupled with a sense of inescapability, aggressiveness, sleeplessness, indigestion, loss of appetite, extreme loss of weight ranging to physical decline, erosion of personality, destitution, triggering/formation of psychoses possible

→ *Dependence*
Very severe, rapidly progressing psychological dependence

Designer drugs and sniffing agents

Designer drugs (analogues to controlled substances) are manufactured synthetically in private laboratories. During manufacture the chemical composition of a source substance is altered, or, alternatively, a new drug not derived from a natural basis is designed. Here an attempt is made to preserve, or achieve, the effect of known drugs falling under the narcotics law. The point of altering the chemical formula is to circumvent the narcotics law, until such time as the new drug is declared illegal. Designer drugs are swallowed, injected, or sniffed.

Sniffing agents are volatile substances, mostly liquid organic solvents (acetone, gasoline, etc.) which when inhaled lead to a buzz, to a state of inebriation, and often even to loss of consciousness. This group includes adhesives and glues, paint thinner, nail-varnish remover and much else besides. Abusers are mostly children and teenagers. A later transition to illegal drugs is often observed.

Designer drugs and sniffing agents

Effects

Designer drugs: *depending on chemical composition, dull senses (opioids), ranging to euphoria-inducing and hallucinogenic effects*

Solvents: *sought is a changed existential orientation, inebriation, unusual and enhanced sensory perception, clouded consciousness ranging to loss of consciousness*

Acute risks of abuse

Designer drugs: *depends on substance*

A particular risk factor is the unknown chemical composition of the substance. Duration of inebriation, intensity of inebriation and side effects are hard to predict, acute risk of intoxication.

Solvents: *states of anxiety when inebriated, panic reactions, death by suffocation while unconscious, burns and corrosion in respiratory tract*

Long-term effects

Designer drugs: *depends on substance*

Solvents: *narrowing of interests, retarded development, "dropping out", chronic headaches, sleeplessness, giddiness, poor appetite, severe organic and nervous damage by individual agents have been observed, in case of long-term abuse dementia (idiocy), spastic paralysis*

Dependence

With both substance groups considerable psychological dependence; with designer drugs physical dependence cannot be ruled out

Addicted behaviour

Gambling

Humans have been playing ever since the dawn of culture. They have tried things out, have playfully invented instruments, and have thus acquired know-how and power. Some of this is still present in the "play instinct" children and adults have. Many people also experience fascination while playing, as is evident, for example, in the way young people play computer games, although no money is at stake.

The earlier gaming machines operated purely randomly, the machine being designed always to have the better chance of winning. Today's gaming machines convey the idea (through intervention options like start/stop and risk keys) that the player can actively intervene in the game, making winning or losing no longer a matter of pure chance. The apparent challenge boosts the fascination, but the chances of winning – actually prescribed by law – are practically the same as before.

"Pathological gambling syndrome", to give it its medical name, is almost exclusively restricted to men; only about one gambler in ten is a woman. Pathological gambling is often initiated by a large win. Compulsive gamblers seize upon every chance they get to gamble, doing so till they have lost all that they have and all that they can otherwise borrow or lay their hands on. The results are ruined marriages, running up debts, losing one's job, and criminality to raise the necessary cash. Since 1980 gambling has been classed in the U.S.A. as a psychological disorder.

Casinos and the placement of gaming machines in restaurants, plus the stress resulting from expectation, tempt people to excessive consumption of alcohol and nicotine. The various forms of addiction are, in any case, intertwined as a result of the basic proclivity to addiction on the part of the sufferer. Abuse of alcohol and other addictive substances is therefore more the rule than the exception in compulsive gamblers.

Eating disorders

No firm data exist on the number of people with eating disorders. Experts and therapeutic bodies assume that some 90% of those afflicted are female, though counselors report an increase in the share of males seeking advice.

But by no means all of those with eating disorders show symptoms of addicted behaviour; in particular, by no means all overweight persons have a fixation on eating and/or their weight, indeed overweight in many cases is an expression of a physical complaint. Depending on the characteristic kind of eating habit and body weight, three or even four forms of disturbed-eating syndrome are distinguished:

Adiposity (obesity)

In one group of those suffering from excessive appetite, bouts of eating or non-stop eating lead to considerable overweight, placing a strain on heart, blood circulation, and skeleton, and over the longer term favouring the incidence of diabetes, high blood pressure, myocardial infarction and joint complaints. Afflicted persons suffer from an inferiority complex, difficulty in making new contacts, and social discrimination. The term "latent adiposity" refers to a proclivity to overweight.

An eating disorder exists when concern about one's own body weight and constant dieting dominates life. The chief symptom of addicted behaviour, inability to control oneself, is however not present.

Bulimia
(Bulimia nervosa)
Bulimia is characterized by a cycle – sometimes repeated several times a day – of bouts of ravenous hunger and self-induced vomiting. Bulimia sufferers are mostly of normal weight, but desire to be thinner than they are. Failure in their efforts at self-control plus an eating habit they experience as perverse, lead to extreme feelings of guilt and shame; they also isolate the sufferer. The constant loss of gastric juices from vomiting causes similar physical damage, as does the abuse of laxatives and diuretics; excessive acid in the oral cavity leads to dental decay.

Anorexia
Anorexics eat the bare minimum of food and are assiduous in their efforts to become "skinny"; they think they are far too fat. As a rule, they are hyperactive and manifest considerable ambition in athletics, at school, in the workplace. Eating is seen as drive satisfaction and rejected. Their sole pride and joy is in asceticism.

Some sufferers literally starve themselves to death. Forced feeding in a clinical setting may become necessary to save life.

For all their outward diversity, those with eating disorders have much in common. For example: fixation on food-related issues, a distorted body image, lack of acceptance of one's own body, an incapacity for unencumbered enjoyment.
Between the various forms of disturbed-eating syndrome there is a seamless transition. Thus, about half of all anorexics also experience phases of bulimia with extremely negative results for their self-esteem, whereas those normally suffering from bouts of eating also know times when, like anorexics, they derive satisfaction from starving themselves.
Widely encountered, too, is additional alcohol and medicament abuse. Causally related to eating disorders are (apart from the abuse of appetite depressants) the abuse of laxatives and diuretics, with the intention of losing weight. Both these medicament groups lead to water loss (hence the seeming loss of weight) and therefore to a lowering of sodium and potassium levels. The consequences: severe repercussions for the kidneys and the myocardium, as well as osteoporosis formation. The body's natural metabolism is hampered, the result being renewed medicament abuse.

Adresses

Here's how to find a counseling centre or self-help group

The telephone book lists counseling centres under the headings "Addiction counseling centres", "Psycho-social counseling centres" and "Youth and drug counseling centres".

The various associations of public welfare aid, the local public health offices, and crisis telecounseling will be happy to inform you about counseling centres in your local area. Supra-regional telephone counseling is available under the following emergency number:

Sucht & Drogen Hotline
(Addiction and drug hotline)
(in Germany) 01805/313031 (12 cents/minute)
Manned 24 hours a day Mon. to Sat.

Drug emergency hotline providers in Berlin, Düsseldorf, Essen, Frankfurt, Hamburg, Cologne, Munich and Nuremberg have joined forces to provide nationwide telephone counseling on addiction and drug issues for persons directly affected and their relatives.

Further information and the addresses of support agencies in your locality are available from:

Deutsche Hauptstelle für Suchtfragen e.V. (DHS)
(German Centre for Addiction Issues)
PO Box 1369
D-59065 Hamm, Germany
Tel.: +49 (0)2381 9015-0
Fax: +49 (0)2381 9015-30
info@dhs.de
www.dhs.de

Bundeszentrale für gesundheitliche Aufklärung (BZgA)
(Federal Centre for Health Education)
www.bzga.de
BZgA Information Telephone
(in Germany) 0221 89 20 31
Mon.- Thurs. 10 a.m. - 10 p.m.
Fri., Sat., Sun. 10 a.m. - 6 p.m.
The BZgA Information Telephone answers questions on addiction prevention. For alcohol and other dependency problems the BZgA Information Telephone offers a first point of contact for personal advice with the aim of directing those seeking help to appropriate local relief and counseling services.

The pastoral care hotline (»Samaritans«) provides anonymous counseling free of charge around the clock and can recommend appropriate counseling centres.
(in Germany) 0800-1110111 or 0800-1110222

All the counseling centres can provide you with the contact details for existing self-help groups in your locality. Or you can contact the following directly:

Al-Anon Familiengruppen, Essen – self-help groups for the families and friends of alcoholics
Telephone: 0201 773007
www.al-anon.de

Alateen, Essen – self-help groups for young people who have alcoholics in their family
Telephone: 0201 773007
www.al-anon.de

Anonyme Alkoholiker (AA) – Alcoholics Anonymous, Munich
Telephone: 0 89 3 16 95 00
www.anonyme-alkoholiker.de
nationwide hotline: area code + 1 92 95

Arbeiterwohlfahrt Bundesverband e.V. – workers' welfare association
Tel.: 02 28/66 85-157 or -0 (switchboard)
www.awo.org

Blaues Kreuz in Deutschland e.V., Wuppertal – Blue Cross in Germany,
Telephone 02 02 6 20 03-0
www.blaues-kreuz.de

Blaues Kreuz in der Evangelischen-Kirche, Bundesverband e.V., Dortmund – the national association of Blue Cross units within the Protestant Church
Tel.: 02 31 5 86 41 32
www.blaues-kreuz.org

Freundeskreise für Suchtkrankenhilfe, Bundesverband e. V., Kassel – the national association of circle of friends' organisations for addiction relief
Telephone 05 61 78 04 13
www.freundeskreise-sucht.de

Bundesverband der Elternkreise drogengefährdeter und drogenabhängiger Jugendlicher e. V., Berlin – the national association of parent groups with children at risk of or suffering from drug addiction
Telephone 030 556702-0
www.home.snafu.de/bvek

Bundesverband für stationäre Suchtkrankenhilfe e. V., Kassel – the federal association for inpatient addiction relief
Telephone 0561 779351
www.suchthilfe.de

Deutsche Gesellschaft für Suchtmedizin e. V., Hamburg – the German Society for medical treatment of addiction / addiction medicine
Telephone 040 42803-5121
www.dgsuchtmedizin.de

Deutscher Caritasverband e. V. Referat Basisdienste und besondere Lebenslagen, Freiburg – the department of the German Caritas welfare organisation dealing with basic services and critical situations in life
Telephone 0761 200-369
www.caritas.de

Deutsches Rotes Kreuz e.V. – Generalsekretariat, Berlin
– headquarters of the German Red Cross association
Telephone 030 85404-298
www.rotkreuz.de

Fachverband Drogen und Rauschmittel e. V., Hanover
– specialist association on drugs and addictive substances
Telephone 0511 18333
www.fdr-online.info

Fachverband Glücksspielsucht e. V., Herford – specialist gambling addiction association
Telephone 05221 599850
www.gluecksspielsucht.de

Fachverband Sucht, Bonn – specialist addiction association
Telephone 0228 261555
www.sucht.de

Gesamtverband für Suchtkrankenhilfe im Diakonischen Werk der Ev. Kirche in Deutschland e. V., Berlin – the umbrella organisation of addiction relief units within the Protestant Church in Germany
Telephone 030 83001-807
www.sucht.org

Guttempler in Deutschland, Hamburg – the Good Templars in Germany
Telephone 0 40 24 58 80
www.guttempler.de

Kreuzbund e.V., Hamm – self-help and supporters' association for people suffering from drug addiction and their relatives
Telephone 0 23 81 6 72 72-0
www.kreuzbund.de

Paritätischer Wohlfahrtsverband - Gesamtverband e.V., Referat Gefährdetenhilfe, Frankfurt – non-denominational welfare association, department dealing with support for people at risk
Telephone 0 69 67 06-269
www.paritaet.org

Verband ambulanter Beratungs- und Behandlungsstellen für Suchtkranke/Drogenabhängige e. V., Freiburg – association of outpatient counseling and treatment centres for people suffering from drug addiction or dependency
Telephone 0761 200363
www.vabs.caritas.de

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