The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 10, Issue 2, April- June, 2022
DIP: 18.01.025.20221002, DOI: 10.25215/1002.025
https://www.ijip.in

The International Journal of INDIAN PSYCHOLOGY

Case Study

Psychiatric Social Work Intervention for Substance Addiction: A Case Study from the Indian Point of View

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ABSTRACT

Drug Addiction is a continual, chronic, reoccurring psychological and physical disease that is characterised by habitual and obsessive drug seeking behaviour and use, regardless of detrimental results. Drug addiction is associated with impairment in various aspects of physical, psychological, and socio-occupational functioning. Psychosocial interventions for mental health and substance use disorders are interpersonal or informational activities, techniques, or strategies that target biological, behavioural, cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being. ***Methodology:*** The case is based on a single subject research design through an in-depth case study using face to face interview with client and family. The case presented here was a 29-year-old Hindu, unmarried, male graduate from Haryana, who came from a rural background and had multiple psychosocial problems. Case study is a good fit with many forms of social work practice used widely by Psychiatric Social Workers and other mental health professionals as well. The case study was conducted in the psychiatric ward of GMCH Chandigarh. ***Results:*** Findings of the study illustrate the nature and extent of the psychosocial problems in a case of young unmarried men of Drug Addicted. As a result of psychosocial intervention; Patient gets the benefit of understanding and awareness about the illness and various other psychosocial problems as well. ***Conclusion:*** This case study indicates that psychosocial intervention with pharmacotherapy is more effective so it can be a good choice of the treatment of Substance Addiction. The single case design has its own limitations. As a result, generalization should be used with caution.

Keywords: *Drug Addiction, Psychosocial Intervention & Problem Solving*

Drug addiction is a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences (National Institute on Drug Abuse, 2014). Drug addiction is associated with impairment in various

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Received: April 02, 2022; Revision Received: May 16, 2022; Accepted: May 21, 2022

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aspects of physical, psychological and socio-occupational functioning. Drug addiction is a growing problem in India and the world. The most common use of drug in India is alcohol, followed by cannabis and opiates. Drug use, whether licit or illicit, causes serious health problems in individuals. The National level survey conducted on drug use in India indicated that prevalence of drug abuse among males in the general population is significant. Drug abuse among women also exists despite the fact that more men use drugs than women, the impact of drug use tends to be greater on women, because women lack access to care for drug dependence.

Financial burden disturbed family environment, violence, and psychological problems are other consequences of drug abuse in the family. Adolescent drug abuse is another major area of concern because more than half of the person's with substance use disorder are introduced to drugs before the age of 15 years. Millions of Indians are dependent on alcohol, cannabis, and opiates, and drug misuse is a pervasive phenomenon in Indian society, says a new report, published jointly by the UN Office on Drugs and Crime and India's Ministry of Social Justice. World Health Organization (WHO) defines Drug; it is a chemical substance of synthetic, semi synthetic or natural origin intended for diagnostic, therapeutic or palliative use or for modifying physiological functions of man and animal.

Drug addiction is now prevalent everywhere in India; in the house, streets, in the workplace, parks, slums, markets and even in educational institutions both in rural and urban areas. Virtually all segments of society are severely affected by this problem. Effects of drug abuse know no bound; there are physical, psychological, familial, social, economic and National effects. Drug addiction leads to disintegration of family lies. The drug addicts in a threat to the family Because of the hostile behavior of the drug abuser the family in at risk. Normal activities of the family disrupts due to antisocial activities of the abuser. The drug addict youth drops out from schools, college or university education Social isolation and alienation are very common. Family of the drug addict became isolated from the community and the society.

Case Summary of the Patient: Mr T.S. is a 29-year-old male patient. He was referred by his psychiatrist for psychological assessment and management of the patient's problem. The patient was presented with complaints of drug addiction, poor problem solving, poor abstract reasoning, and poor communication skills. Assessment was done at both the informal and formal levels. For informal assessment, a clinical interview was conducted; a mental status examination was done; a subjective rating of symptoms was taken; a life event chart was used; and for the purpose of formal assessment, a drug abuse screening test was used. The score suggests that the patient has a severe level of problem. For the aim of management rapport building, psycho-education, supportive psychotherapy, relaxation techniques, the ABC model, cost-benefit analysis, addiction cycle, break-up cycle, written ventilation, assertiveness training, and trust circle, written ventilation, the road map technique, and relapse prevention technique were used. The process resulted in an improvement in desirable behaviour overall.

Socio Demographic Profile of the Patient: Mr. T.S., 29 years old, male, graduate, unmarried, unemployed, belongs to a Hindu nuclear family of middle socio economic status, resident of Haryana.

Source and Reason for Referral: Patient was referred by a psychiatrist, for psychological assessment and management of the problem of the patient.

The Chief Complaints of the Patients:

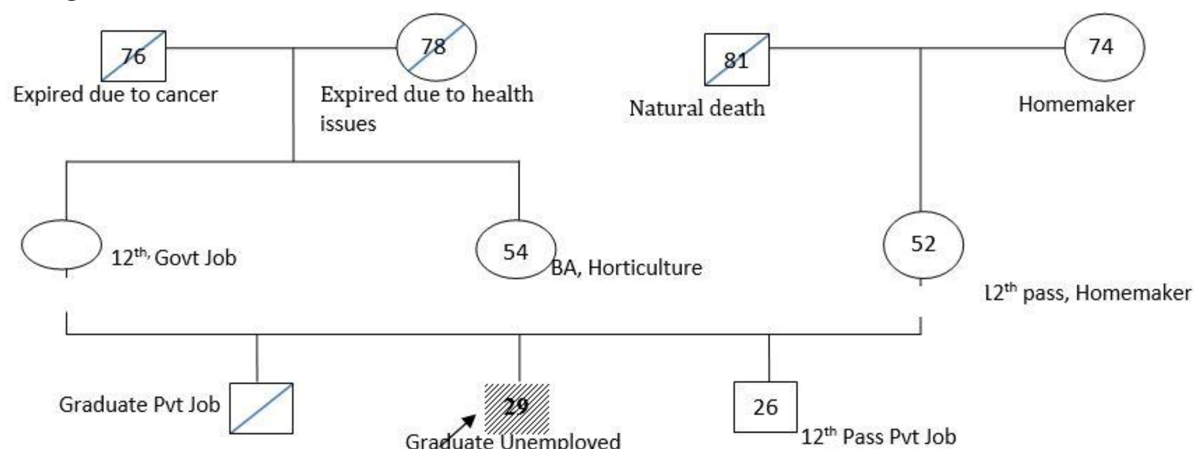
Drug addiction	since 9 years
Low mood	since 7 years
Poor problem solving	since 5 years
Passive communication	since 5 years
Poor decision making	since 5 years

Diagnosis of the Case: It was diagnosed that the patient has Stimulant withdrawal and Cannabis withdrawal

History of Present Illness: According to the patient, he started stealing about 8 to 9 years ago. At the start, he just uses it to steal the things that were the patient's needs, and he belongs to a middle-class family, and his parents cannot fulfill his expenditures. With time, stealing became more like a habit of the patient than a need, and he habitually started stealing, as, according to him, he was so used to it and was unable to get rid of his stealing habit. According to the patient, his home atmosphere was very distant and was not communicative. His parents were extremely neglectful, so the patient began to form friendships outside the home; soon, he formed a group of aged friends, and to make adjustments, he began to follow their rituals. According to the patient, he seeks pleasure and excitement in everything that he does with his friends. He had realised that his company was not good and appreciated by society, but he didn't want to leave then, as he was getting all the emotional and social support from them, and he didn't want to lose the support and break the circle at any cost. His friends were already involved in several unethical acts, such as stealing and trafficking goods, and in order to please his friends, he did whatever was asked of him to do. He started smoking cigarettes under the influence of his company. When his family scolded him when he came to know about his bad company, the client got very disheartened, and to gain some emotional support, he went to his friends, who offered him a cigarette, and the patient accepted it. With time, as his tolerance developed with smoking, he took a step forward and stopped smoking, as for him, it was not a source of relief or pleasure for him.

The patient started taking hash. He used to take it at friends' gatherings, as he was already vulnerable to it. He reported that he had been hashing for about 3 to 4 years. He stopped taking hash and then taking heroine, which provided him more relief than hash, as he reported. He took heroine for 2 years, and then shifted to chemical addiction, in which he used to inject anti-depressive and anti-histamine medicines into his body that made his condition worse. Keeping in view of the patient's day-by-day progressing problems, he was taken to a drug addiction centre in Chandigarh by his family, where he may not get access to any kind of drug. At the start of the patient's treatment, he reported the symptoms of drowsiness, restlessness, muscle tension, somatic pains, laziness, nausea, fever, and severe craving for drugs, but currently the patient seems energetic, motivated, and a little craving for drugs is reported by him.

Genogram



Family Composition
Father: Mr JS, 58 years, Male, 12th pass, Govt job
Mother: Mrs. RS, 52 years old, female, 12th grade pass, homemaker
Siblings
Mr. SS, 31 years old, married, graduate, government job.
Mr. TS, 29 years old, male, single, graduate, and unemployed
Mr. SS, 30 years old, unmarried, 12th, Pvt Job

Family Dynamics
Boundaries: Closed and rigid boundaries were found in the family as the father of the patient did not allow much interaction with friends and relatives, and even the internal boundaries were rigid and closed between the parental subsystems**.**

Subsystems: There are three types of subsystems found in the family. The parental subsystem, which was very well formed, the sibling subsystem, which was not well formed, and the parent-child subsystem were all analysed.

Family Developmental Stage: According to the Family Life Cycle (Duvval-1977), a family is in the 6th stage, launching young adults into the world.

Leadership Pattern: Patients' father was both the nominal and functional leader. Leadership pattern was autocratic, but his leadership was accepted by all the family members. The decision-making pattern was authoritative in nature, where the father usually dominated the other members with firmness and self-assurance, and the other family members were not included in the decision-making process.

Role Structure and Functions: in this family, the role allocation was not clear and sound. Every member of the family performed their roles, but not satisfactorily. There was no role strain present in the family.

Communication: Direct communication existed between the father and the mother, but the noise level was high at times. There was minimal communication between the patient and father, and the patient used switchboard communication to communicate with the father, the

mother being the communicator so as to avoid confrontation with the father. The noise level in the family had risen when the patient was indulging in drugs.

Reinforcement Patterns: The reinforcement strategies in the family were found to be inadequate as they scolded the patient for his undesired behaviour and did not use praise to motivate the desired behaviour. Negative reinforcement in the family was presented in the form of criticizing and scolding the patient for his activities. No differential reinforcement pattern was used by the parents.

Cohesiveness: Cohesiveness was present in the family to some extent, but we felt it was lacking. Emotions and social and personal activities were not shared among the family members. The family members did not share meals together or get involved in other activities as a family.

Family Rituals: The family rituals were performed regularly in spite of the patient's drug-addicted behaviour.

Adaptive Patterns: The family possessed inadequate problem-solving ability. The father tried to blame the mother for most of the problems and assumed a non-participative role in solving them. The patient had difficulty with conflict resolution, which might possibly have been due to drug intake, and adopted unhealthy ways of dealing with stress like denial and escape.

System of Social Support
Primary support: The family had adequate financial resources but primary emotional support was inadequate, especially not extended to the patient.

Secondary support: Secondary support in terms of help from friends and relatives was adequate but not utilized.

Tertiary Support: The tertiary social support system is good in the form of GMCH, where the multidisciplinary team, which includes psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses, fulfills the needs of the patient.

Personal History: The patient's premorbid personality was social, active, energetic, and outgoing, and his nature was loving and caring. He said that most of the friends that he made to support him were selfish and only extracted their own benefit from him. Other friends were involved in theft and addiction, which motivated him to get involved in those acts. He reported that in his whole life he had never fought with anyone, and had not even used harsh tones or abusive words. He used to help anyone he thought was in trouble, and he would often steal just to help a friend or another person.

Educational History: Throughout the period, patients' schooling was provided by a government school. He was a good student and always got good grades. He likes reading and exploring different books. His education had ended at the graduate level, and he was unable to continue his studies because the family could not afford the additional costs. His relationships with his teachers, fellows, and friends were good, and he used to respect everyone. He had never gone through any kind of adjustment difficulties, as he was a social person and was good at making adjustments.

Occupational History: The patient has a long occupational history. He had worked in four places. The posts on which he worked were computer operator and data entry. The reason for several job shifts was that he was caught several times when performing the theft. Several times, he was hired on warning.

Marital and sexual history: The patient's age of puberty was 12 years. Through his friends and the internet, he got knowledge about puberty signs. His reaction to the hormonal changes was excited. His attitude towards sex was positive. The patient himself indulged in the sexual activity when he was 22 years old. He had a proper sexual relationship with his girlfriend. The relationship lasted for one year but ended in a break-up. Currently, the patient reported that he had a strong feeling of guilt associated with his past love affair.

Family History: The patient belongs to a middle-class family. He lives in a nuclear family system. His father is a government employee and is, by nature, a strict person and the authoritarian figure of the family. The patient didn't have satisfactory relations with his father because, according to him, he never gave quality time to him like all fathers gave to their children. He said that his father loves his work more than his family. Overall, the family environment was restrictive, and there were so many gaps present in the family's communicative system.

History of Family Psychiatry and Medical Illness: There is a family history of psychiatry and medical illness as the patient's elder brother is also a substance abuser and his mother is hypertensive.

Provisional Formulation: It is provisionally hypothesized that the patient has cannabis withdrawal and inhalant intoxication effects because he was using multiple addictive substances, and after leaving the drugs, he showed withdrawal symptoms for a month.

Psychological assessment: In order to assess the patients' problems, two types of assessments were carried out, which included informal and formal assessment.

- *Informal Assessment:* It is comprised of a clinical interview and a mental status examination.
- *Formal Assessment:* The formal assessment was comprised of a drug abuse screening test.

Clinical Interview: It is a face-to-face encounter in which the clinician asks questions about the patient's problems, their responses, and reactions. The clinician collects detailed information about the person's problems, feelings, lifestyle, relationships, and other personal history (Comer, 2004). A clinical interview was conducted with the patient to get detailed information about his family, personal, and history of psychiatric problems. He had proper insight into his problem, and he was motivated to seek treatment. During the interview session, the patient was very unhappy and was attentive.

Mental State Examination: A mental state examination is done with the patient at first presentation to the psychiatric social worker or clinical psychologist to assess his or her verbal and nonverbal symptoms of illness. It provides a basis for psychiatric diagnosis and clinical assessment (Goldman, 1988). The patient was wearing jeans, pants, and a shirt. He was a neat and tidy man of average height. His appearance was consistent with his reported age. He was a well-mannered person. His personal hygiene was good. His gait was active

and energetic. The patient was much more compliant and was maintaining good eye contact. He seems to be very cooperative, attentive, and interested in the session. He was vigilant and alert and was actively listening. His orientation was good as he responded accurately when asked about the place, season, year, date, month, time, and city. His rate of speech was normal, and his tone was soft. The quality of speech was emotional. His mood was in sync with his affect; he was upbeat and energetic. His thought process was logical, goal-directed, appropriate, and relevant to the situation. His judgment was good and appropriate. His attention and concentration were proper as he performed correctly in digit span, spelling backward, and calculations. His memory, intellect, and vocabulary were good. He was able to recall the event from the past easily. His knowledge and vocabulary were proper as he correctly stated the names of the president of India, the prime minister, and the capital city. He was good at abstractions too, as he clearly stated the difference between two objects and commonly used proverbs.

Case Formulation: The patient was a 29-year-old male who was referred with complaints of drug cravings, sadness, worthlessness, and self-dislike passivity and muscle pains. The history of the patient suggests that his childhood was not good and he didn’t have attention, love, and affection from his parents. He was a neglected child. He also belongs to a middle-class family where his needs and desires were not fulfilled. These factors proved to be the predisposing factors to the patient’s problem. The patient's background information revealed that he does not accept responsibility for anything or issue on his own, instead blaming his parents and the external environment for his problems. The patient was not ready to accept his fault, and for social approval, he wanted people to feel sorry for him.

The patient’s elder brother was also an addict, and the patient got inspired by his personality and learned from his behavior. People learn behaviours from their surroundings, according to social learning theory, and this modeling behaviour is very common in addiction (Comer, 2002). Because the patient was neglected at home, he began to spend more time outside of the house and try to make friends in order to gain some emotional support and unconditional positive regard. Unfortunately, the people he found were already involved in illegal acts like stealing and drug addiction. The patient didn’t understand the difference between right and wrong at that time, and started to adopt the norms of the group to adjust to it. That is why he did whatever was asked of him to do, and remained in the company of his friends. He started smoking at first and moved to hash. According to Lapidus (1980), peer pressure was found to be an important reason for drug use. So, in the present case, the above mentioned factors were considered as precipitating factors. So, in this case, the patient's nature of blaming others for his faults, bad company, and relationship break-up proved to be the maintaining factors in this case. Currently, the patient has proper insight about his problem and is highly motivated to seek treatment. Other than that, the patient’s family is also supporting him to get him out of his problem.

Intervention Plan: The intervention plan was designed to help the patient to resolve the problem he is facing and to aid the natural process of adjustment, to develop a positive self-concept and to save him, and to learn to interact with others.

Short Term Goals for the Patient of Substance Addiction

1. By using supportive therapy, you build a level of trust with the patient and create a supportive environment that will allow the patient to share his problems.
2. Psychotherapy teaches the patient about the harmful effects of substance use.

3. Asking the relevant questions to probe the underlying factors of his problems.
4. Explore experiences from the patient's early life that contributed to developing the problem.
5. Active listening, positive reinforcement, reassurance, and unconditional acceptance to facilitate his sharing and catharsis.
6. Implement appropriate relaxation techniques to enable him to manage his stress and to get relaxed in anxiety-provoking situations and thoughts.
7. Explore experiences from the patient's early life that contributed to his addictive behavior.
8. Ask him to complete the Cost Benefit Analysis and to write down the advantages and disadvantages of his addictive behaviour and present lifestyle.

Long Term Goal for the Patient of Substance Addiction

1. Proper follow-up sessions with the patient, to revise short-term goals and to incorporate new skills and techniques to make the patient proficient.

Implementation of Therapeutic Strategies

Rapport Building: Rapport is the ability to relate to others in a way that creates a level of trust and understanding. It is the process of responsiveness at the unconscious level. It is important to build rapport with your patient as it gets their unconscious mind to accept and begin to process your suggestions. They are made to feel comfortable and relaxed, and are open to suggestions. This technique was done with the therapist (Psychiatric Social Worker) to maintain a sound therapeutic relationship with the patient. Rapport was built with the patient so that he could easily share all his problems. It helped the client to enhance their communication level in a positive way. It was also built to gain the confidence of the client.

Supportive Psychotherapy: Supportive psychotherapy is an attempt by a therapist to help patients deal with their emotional distress and problems in life. The therapist provides an emotional outlet, the chance for patients to express themselves and be themselves (Werman & David, 1984). Supportive psychotherapy was done with the help of therapist (Psychiatric Social Worker) in order to enhance the relationship with the client and provide him with reassurance, guidance, and unconditional positive regard. So that he easily shared his real life events and his feelings regarding these events and both worked in a productive way. The five steps of psychotherapy, which were therapeutic relationship, listening, emotional release, information, advice, and encouraging the hope of the client, were done during management.

Psychoeducation: Psychoeducation is offered to people who live with a psychological disturbance. A goal is for the patient to understand and be better able to deal with the illness presented. Also, the patient's own strengths, resources, and coping skills are reinforced in order to avoid relapse and contribute to their own health and wellness on a long-term basis (Winkle, 2008). Psychoeducation was provided to the patient to develop an insight in him about the problems through which he was going through and the effectiveness of the management. The patient was psycho-educated regarding the effects of drugs that he had on his life, relationship, and health. By using a bio-psycho-social model, the patient was educated regarding the treatment and the course of it.

Relaxation Techniques: Relaxation techniques are used to deal with the symptoms of distress. It helps with feeling relaxed and in a better state of mind. A relaxation technique

was used with the patient in order to make the patient relax and feel better and to deal with his stress symptoms. Progressive muscle relaxation was used because he reported muscle stiffness and pain. At first, a deep breathing technique was used in which the patient was asked to sit in a comfortable posture, make himself relax, inhale air from the nose, for 2 to 3 seconds, leave the air inside the lungs, then smoothly exhale the air out of the mouth. The patient was asked to repeat the exercise 3 to 5 times to make him proficient in the technique. After that, a progressive relaxation technique was used. This technique is used for learning to control the state of tension in one muscle group. (Jacobson, 1938) After giving detailed instructions and demonstrations, the patient practices the technique during the session.

Cost-Benefit Analysis: Reviewing the positives and negatives, or carrying out a "cost-benefit analysis", can be a powerful way of influencing the motivation to do certain things (Glickman, N. 2009). A cost-benefit analysis was done to make the patient aware of the negative effects of drugs and the positive effects of withholding them. The patient was himself asked to list the positive and negative effects of drugs. After enlisting the points, the patient was asked to read what he had written, compare the cost and benefits, and subtract the cost's benefits, and then draws a conclusion based on what the two lists of pros and cons suggested. The outcome of the technique was positive and the high rate of cost helped him to recognize that he had spoiled his life by being under the influence of drugs.

Assertiveness Training: Assertiveness training was introduced by Andrew with the notion that a person could not be both assertive and anxious at the same time, and thus being assertive would inhibit anxiety. This technique was used with the patient because he was very passive and the patient's addiction was in a way linked to his passivity, as he could not say "No" to anyone, and used to affect himself just to please others and save the relationship. First, three types of communication, i.e., passive, assertive, and aggressive, were discussed with the patient, and he was asked to rule out his present communication style, and also the best style that he wanted to follow. The patient chose the assertive one. He was also given homework to practice the technique with everyone in the hospital or at home. The outcome of the technique was very positive, and observable changes were seen in his communication patterns and social skills.

ABC Model: In the ABC model, the patient is told that his negative and irrational beliefs or behaviours are causing disturbances in his life. The rationale was explained to help the patient understand his beliefs or behaviors and to replace the dysfunctional beliefs or behaviours with functional ones. The ABC model was explained in which the patient was told that there can be any stressful event that can become the antecedent of a poor consequence, and the thing that actually leads to a poor consequence is a faulty belief or behavior. The outcome of this technique was positive, and he easily understood the concept and the connections between A, B, and C, and was able to relate the model to his real-life experiences.

Written Ventilation: It is a kind of catharsis technique that is used for relationship breakup, trauma, loss of a loved one, and repetitive thoughts about any person or thing that is no more, or in the case of any unfulfilled business. In this technique, the patient is asked to write a letter to someone with whom he has some concerns to show and some complaints. The patient was asked to write a letter to her past love and to his parents regarding his concerns and complaints. The patient reported that after writing the letter to his loved one,

and after sharing and uncovering all his conflicts, he felt much more relaxed, had no thoughts about his breakup, and felt happy in his life.

Relapse Prevention Technique: The relapse prevention approach is used with the patient to develop coping skills to manage high-risk situations, to make lifestyle changes to decrease the need for drugs, to prepare for interruption of lapses so that they do not lead to relapse, and to prepare the patient for managing relapse so that potential harm may be minimized. In this relapse prevention technique, the patient was asked to explore the situations, events, and triggers that may have led to relapse in the past. Goal setting was also done at this step, in which the patient was asked to set goals for himself that would make him enthusiastic and keep him away from relapse. The outcome of the technique was positive. The patient was fully aware of his problem, and by setting goals and identifying triggers, he became aware of how to avoid relapse.

Outcome of the Intervention: From the first session to the last, the patient's problems improved. His behaviour improved to a large extent. The patient has no craving for drugs; his communication pattern has increased to a large extent. Other than this, marked improvements are seen in the patient’s mood, behaviour, and somatic pains. Hence, positive observable changes are seen in the patient’s mood and behaviour, his problematic behaviours are decreased to a large extent.

Recommendations of the Case Study

1. Family therapy should be provided to the patient’s family.
2. On a daily basis, sessions should be conducted with the patient and his problems and current issues should be inquired about.
3. Proper follow-up should be taken, and new techniques should be applied with the rehearsal of the old ones.

Limitations of the Case Study

1. A distraction-free environment wasn’t available, which created disturbance in the taking session with the patient.
2. The majority of the information could not be cross-checked.
3. No prior psychological treatment was given to the patient.

Follow-up of the Case Study: A follow-up session was held with the patient, and all the implemented techniques were revised. Assertiveness training was revised in detail in that session. The patient was then terminated. It took 30 minutes for that session.

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Acknowledgement
Author acknowledges Shugufta Gulzar for her kind help and support.

Conflict of Interest
The author(s) declared no conflict of interest.

How to cite this article: Paul F. A., Gaga J. K.& Zaid M. (2022). Psychiatric Social Work Intervention for Substance Addiction: A Case Study from the Indian Point of View. *International Journal of Indian Psychology*, *10(2),* 249-259. DIP:18.01.025.20221002, DOI:10.25215/1002.025