COPING AND SOCIAL SUPPORT IN FAMILIES BEREAVED DUE TO DRUG RELATED DEATHS IN AIZAWL, MIZORAM

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Submitted in partial fulfillment of the requirement of the Degree of Master of Philosophy to the Department of Social Work, Mizoram University, Aizawl.

MIZORAM UNIVERSITY

DECEMBER, 2014

DECLARATION

I, Esther Lalrinhlui Ralte, hereby declare that the subject matter of this dissertation is the record of the work done by me, that the contents of this dissertation did not form basis of the award of any previous degree to me or to do the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/Institute.

This is being submitted to Mizoram University for the degree of **Master of Philosophy** in **Social Work.**

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CERTIFICATE

This is to certify that the dissertation *Coping and Social Support in Families Bereaved due to Drug Related Deaths in Aizawl, Mizoram* submitted by Esther Lalrinhlui Ralte, for the award of Master of Philosophy in Social Work is carried out under my guidance and incorporate the student's bonafide research.

The scholar has fulfilled all the required norms laid down for the M.Phil regulations by the Mizoram University. The thesis has not previously formed the basis for award of any degree of this university or any other and this work is a record of the scholar's personal effort carried out under my guidance.

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ACKNOWLEDGEMENT

It is my sincerest gratitude to God for blessing me with the opportunity to complete this programme. I could not have completed this course without His constant guidance and grace.

A special acknowledgement to my supervisor Dr. Kalpana Sarathy, who has been a patient and understanding mentor. Your professionalism and generous input has taught me so much, and I wish that this work in some way would reflect your outstanding ability.

It is with great appreciation that I thank Mr. VL Rengliana, O.C, Aizawl (Mizoram Excise and Narcotics Deptt). Without his help it would have been impossible to collect the data needed for this research.

This may also be extended to all the participants - the community leaders, church representatives and the respondents who were willing to share their personal stories for my case study. Your contribution has made this research a success.

I am also thankful to my family for their continuous support and encouragements.

It has been a delight to work with my fellow scholars (August 2013 – December 2014).

My heartiest appreciation goes to Sarah Lalremruati for helping me in all the processes of this research.

Finally, I thank Dr. E. Kanagaraj, Head of Department, Department of Social Work for giving me the opportunity to conduct this research under the department.

(ESTHER LALRINHLUI RALTE)

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CHAPTER – 1

INTRODUCTION

This study will explore coping, bereavement and social support in families that have lost a member to drug-related deaths through select case studies using a qualitative approach.

1.1 Concept of Drug related death

According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *'drug-related death'* refers to deaths happening shortly after consumption of one or more psychoactive drugs, and directly related to this consumption. Often these deaths are referred to as 'overdoses', although equivalent concepts are also *'deaths directly related to drug use', 'poisonings' or 'drug-induced deaths'*.

Any drug-related death is a tragedy. Loss of a loved one through addiction is treated by society in a much different manner than a death from any other cause and it creates unique bereavement needs. Many bereaved parents in *drug-overdose death* routinely misrepresent the cause of a family member's death fearing that the person's reputation will be greatly diminished or they feel ashamed for the true cause of the death (Feigelman, 2011).

A study on drug-related deaths in London showed the classification of drug related death as certified by London audit of drug-related overdose deaths are - injury (accident or misadventure) and the remaining certified as open, suicide, and one as natural causes (Hickman, et al,2006).

1.2 Concept of coping

According to the Scottish National Forum on Drug-related Deaths (2008), coping with guilt can be one of the most difficult aspects of bereavement. Pain may be felt in trying to accept that they were not able to prevent the death of someone close to them and regret for things not said or done. When someone died of a suspected overdose, it may attract public interest and the media may report circumstances. This can be very stressful, particularly when insensitive or inaccurate information is communicated or, for example, it focuses only on the problems the person had without mentioning the good things about them.

1.3 Concept of Social Support

The drug-death bereaved often face social stigmatization from family, friends, co-workers and acquaintances, the drug-death bereaved offer more reports of stigmatization than those whose children had died from accidents and natural causes. *What sets these mourners apart from most other bereaved parents is the scarcity of drug death- specific literature to guide them along their difficult healing journeys following their children's deaths* (Feigelman, 2011).

Research has suggested that bereaved individuals identify bereavement as a social stressor, reporting lack of role clarity and support. People grieving various types of deaths have reported feeling as though their grief has been stigmatized. They feel that others are uncomfortable around them and so distance themselves, and they experience direct or indirect social pressure to become "invisible mourners". (E. Bailley, Steven; Dunham Katherine; Kral Michael J, 2000)

1.4 Concept of grief

Disenfranchised grief often results from stigmatized losses, particularly when there is an assumption that the death was caused by the deceased's disturbed or immoral behavior. In addition to being a universal human phenomenon, grief is highly individualized, multi- dimensional, and encompasses pervasive effects on the bereaved .These effects include multiple and interactive affective, behavioral, cognitive, social, somatic, and spiritual components. Following their children's deaths, majority of drug-death-bereaved parents are confronted with avoidance and occasional acts of outright scorn expressed toward them and their children from some of their significant others. Approximately half of the drug-deaths and the suicide bereaved parents reported hearing blaming comments following the death where close family members or friends blamed the deceased child or the parent for the death (Feigelman, 2011).

1.5 Drugs related deaths- Mizoram

The mid1980s in India witnessed an epidemic of heroin injecting in north - eastern states of Manipur, Nagaland and Mizoram. During the 1990s a new epidemic of pharmaceutical drug injecting, notably with buprenorphine occurred in major cities of India (Chowdhuri AN, Chodhuri S. 1990).

The issue of substance abuse and its related social problem has remained a normal phenomenon for the last twenty years in the state. Voluntary actions and governmental initiatives have also been initiated since the mid 80s. At the present, the state has over forty Non-Governmental Organizations and Community Based Organizations to combat the epidemic during the last ten years, Mizoram had witnessed quite a lot of Non-Governmental Organizational activities in the field of drug abuse and not to mention the initiatives taken by the State Government, Community Based Organizations and Churches (In Mizoram Social Defence and Rehabilitation Centre, 2005).

According to the Regional Resource Training Centre, Mizoram and Manipur, the strategic sharing of the two long international borders with Myanmar (404 kms.) and the “Golden Triangle” in the east and with Bangladesh (318 kms) has been accounted for by many thinkers for its vulnerability to substance abuse and illicit trafficking for other illegal goods (in Mizoram Social Defence and Rehabilitation Centre, 2005).

DRUGS RELATED DEATH
(Year-wise) w.f.e. 1984

Year	Male	Female	Total No. of Drug related death for the year	Drugs used		
				Heroin	S/Proxyvon or Parvon Spas	Others
1984	1	Nil	**1**	1	Nil	Nil
1985	1	Nil	**1**	1	Nil	Nil
1986	-	-	-	-	-	-
1987	5	Nil	**5**	5	Nil	Nil
1988	3	Nil	**3**	3	Nil	Nil
1989	6	1	**7**	7	Nil	Nil
1990	7	Nil	**7**	3	4	Nil
1991	7	1	**8**	1	7	Nil
1992	10	2	**12**	2	10	Nil
1993	17	1	**18**	Nil	18	Nil
1994	24	3	**27**	Nil	27	Nil
1995	49	6	**55**	Nil	55	Nil
1996	45	6	**51**	1	50	Nil
1997	56	1	**57**	1	56	Nil
1998	76	8	**84**	1	83	Nil
1999	77	12	**89**	5	83	**1** (1=b)
2000	128	11	**139**	5	131	**3** (3=b)
2001	92	9	**101**	2	98	**1** (1=a)
2002	85	7	**92**	7	84	**1** (1=b)
2003	124	12	**136**	1	133	**2** (1=a+d, 1=c+e)
3004	122	21	**143**	6	132	**5** (1=b, 1=d, 3=f)
2005	35	7	**42**	5	34	**3** (a=b, 1=d, 1=f)
2006	21	1	**22**	1	20	**1** (1=b+d)
2007	25	4	**29**	7	22	Nil
2008	9	2	**11**	4	7	Nil
2009	25	3	**28**	11	17	Nil
2010	13	3	**16**	4	12	Nil
2011	12	Nil	**12**	1	11	Nil
2012	39	6	**45**	3	37	**5** (1=c+g, 2=c+k+g, 1=c+l, 1=m)
2013 (As on 28th June)	13	8	**21**	1	7	**13** (1=h, 1=f+g, 2=n+k, 1=n+k+g, 1=n+d+g+b, 2=n+g, 1=n+d, 1=i+j+k, 1=k+o, 1=j+f, 1=m)
Grand TOTAL	**1114**	**127**	**1241**	**88**	**1131**	**22**

Source: Mizoram Excise & Narcotics Department

OTHERS:

a= Diazepam	b=Dendrite	c=Proxyvon/Parvon Spas
e=Ganja	e=Peptica	f=Cough Syrup
g=Nitrosun	h=Cataspa	i=Respira D
j=Pacitane(pepe)	k=Alprazolam	l=Heroin
m=Unknown	n=Parvon Spas	o=Corazepam.

Aizawl, Dated: The 28th June 2003

1.6 Objectives

1. To profile the characteristics of drug-related deaths that has occurred in Aizawl.
2. To understand the lived experiences of grief and bereavement in relation to drug- related deaths.
3. To identify the coping mechanisms used by the family members.
4. To study the availability of the support systems for families bereaved due to such deaths.

CHAPTER - 2

REVIEW OF LITERATURE

2.1 Substance Misuse

Substance Misuse as a mental health disorder: Substance/drugs misuse has been viewed as a treatable disorder since the 1930's with the advent of Alcoholics Anonymous. Prior to that, various kinds of drugs were often misused, but not considered a diagnosable, treatable health disorder. Drug misuse is categorized through the Diagnostic and Statistical Manual (DSM) (American Psychiatric Association [DSM-IV-TR], 2000) under two basic categories: abuse and dependence. The DSM describes substance abuse as having the following patterns: failure to fulfil major role obligations, substance use in physically hazardous situations, legal problems, and persistent social or interpersonal problems. The DSM describes substance dependence as having the following patterns: increased amounts of the substance; weakened effect with the same amount of substance use; characteristic withdrawal symptoms; substance use in order to relieve or avoid withdrawal symptoms; larger amounts of substance use over a longer period of time; unsuccessful efforts to cut down or control substance use; a great deal of time is spent in activities to obtain the substance; use the substance or recover from its effect; important activities are given up or reduced because of substance use; and continued substance use despite having persistent physical or psychological problems that have been caused or exacerbated by the substance. Drug misuse, as defined in this study, is the use of any kind of drugs to the extent that one could be diagnosed with drug abuse or dependence according to the DSM.

With the emergence of DSM categorizations of drug misuse, came an increased number of treatment options for individuals suffering from drug misuse. While not all treatment models are based on sound theory, scholars have endeavored to develop theories that can explain the process of addiction to better design treatments that address those underlying processes. The most commonly used models of addiction are the moral, socio-cultural, psychological, disease, neurological, and biopsychosocial models (Fisher & Harrison, 2013).

Models of addiction: Six of the most common models of addiction include moral, socio-cultural, psychological, disease, biopsychosocial, and neurological models. The first explanation of drug addiction to emerge was the moral model (Fisher & Harrison, 2013). The moral model of drug misuse posits that individuals

have personal choice and that addiction is a consequence of that person's choice (Fisher & Harrison, 2013). The socio-cultural model of addiction looks for external factors such as culture, religion, family, and peers that influence addiction (Fisher & Harrison, 2013). The psychological model of addiction posits that drug use is secondary to other psychological conditions such as emotional problems that push individuals toward drug use to relieve pain (Fisher & Harrison, 2013). This model also suggests that some individuals have addictive personalities and that pain relief derived from drug use can create bad habits of continual drug use. The disease model of addiction posits that addiction is a disease and that it is not secondary to other conditions (Kurtz, 2002). This model suggests that the disease is chronic and incurable, and that abstinence is the only justifiable goal to treatment. The medical model posits that addictions occur primarily from chemical reactions in the brain (Leshner, 1997). This is one of the reasons why practitioners believe addiction recovery rates are so low (Lewis, Dana, & Blevins, 2011). The biopsychosocial model of addiction explains addiction by combining the socio-cultural, biological, and psychological, cognitive, environmental, and developmental perspective (Fisher & Harrison, 2013).

The cycle of addiction: These models may help us in understanding why some individuals fall into what is called the "cycle of addiction." Research conducted by McLellan and colleagues (2005) have conceptualized addiction as a chronic relapsing condition. In other words, many individuals who misuse substances find themselves caught between a cycle of recovery and relapse. A plethora of research has gone into understanding the phenomenon of "cravings," or the urge or desire to use a substance (Agrawal et al., 2013; Carter & Hall, 2013; Joos et al., 2013; Kavanagh et al., 2013; Witkiewitz et al., 2013). While the craving construct is a complex and ever changing process, researchers agree that cravings are "at the heart" of client relapse (Witkiewitz et al., 2013). Research on cravings has focused on three main explanations: biological, emotional, or cognitive factors. Biological models posit that addiction is a "brain disease" and that the aetiology of addiction is born out of neurobiological processes (Witkiewitz et al., 2013). Emotional models of addiction posit that addiction occurs in response to the avoidance of negative affect such as stress. Cognitive models suggest that addictions are ingrained in cognitive processes such as the cravings associated with seeing a picture of someone drinking alcohol

(Thorberg et al., 2011). The DSM defines withdrawal as "a substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy or prolonged" (DSM, 2000, p. 201). For example, alcohol withdrawal is described as having two or more of the following conditions: hyperactivity, hand tremors, insomnia, nausea or vomiting, hallucinations or illusions, psychomotor agitation, anxiety, and seizures. Because substance withdrawal can be painful, both emotionally and physically, the process of ending the abuse of one's drug of choice can be a long and labour-intensive process. This process may consist of many instances of relapse and recovery before ending the relationship is complete (Miller, 1994). Some organizations, such as Alcoholics Anonymous (AA), suggest that recovery is on-going process and that one's relationship with a substance can never be completely severed (Alcoholics Anonymous, 1972).

Drug misuse treatment: Using the models of addictions as a basis, there are several drug misuse treatment interventions and techniques to help those who suffer from drug misuse (Fisher & Harrison, 2013). Some of the most widely used forms of treatments or interventions include mutual-help groups, cognitive-behavioral therapy, motivational interviewing, contingency management, pharmacotherapy, and family therapy (Fisher & Harrison, 2013; Walters & Rotgers, 2012). One of the most popular interventions is mutual-help groups, often known as twelve-step programs [i.e., AA or Narcotics Anonymous (NA)] (Fisher & Harrison, 2013). These mutual help groups usually follow the disease model suggesting that addiction is a disease and that one is always "recovering" from the disease.

While twelve-step programs exist across the U.S., within outpatient and inpatient treatment settings, cognitive-behavioral therapy (CBT) and motivational interviewing (MI) are widely used treatments (Walters & Rotgers, 2012). CBT is based on the premise that human behavior is largely learned rather than determined by genetics, and that one can use the same learning process used to create the problem to solve the problem (Walters & Rotgers, 2012). Motivational interviewing is based on the idea that those who misuse drugs are ambivalent about change and that questioning can be used to enable individuals to explore and resolve their ambivalence (Miller & Rollnick, 2013). Contingency management is another popular form of treatment whose purpose is to reduce reinforcement derived from drug use and to increase reinforcement derived from healthier alternatives, particularly in

activities where drug use is not compatible (Walters & Rotgers, 2012). Recent strides in medicine have also proved effective the use of prescription medications combined with psychotherapy. To this date, however, prescription medications are only used in the treatment of opioid addiction and alcohol withdrawal (Walters & Rotgers, 2012). Currently, family therapy models which address substance misuse are also increasing (Walters & Rotgers, 2012). Family therapy models that have empirical evidence of their effectiveness with drug misuse include, but are not limited to, Behavioral Couples Therapy, Brief Strategic Family Therapy, and Multidimensional Family Therapy (Rowe, 2012).

2.2 Synthesizing Drug Misuse and Grief

Drug-related grief and loss theory: Drug loss is any loss associated with the relinquishment of drug use whether that loss includes the drug itself, drug-related rituals, friends, self-identity, or any other drug-related loss. According to Jennings (1991), drugs have been described as "cathexis objects - objects that humans invest with psychic energy" (p. 222). Because psychic energy is invested in these objects, emotional attachment has been shown to occur between individuals and their drug (Flores, 2001). Yearning to be with someone with whom attachment has formed is a common symptom for those who suffer the loss of a family, friend, or loved one (Worden, 2009). Yearnings and cravings have also been associated with the relinquishment of drug use (Nees et al., 2012). Jennings explained that drugs can take precedence over human relationships, and that powerful feelings of loss may occur as drugs are surrendered. Jennings continues by stating that drug loss has been typically seen as something that one celebrates, and that grieving is not necessary in losing something that is perceived as destructive. Because individuals who enter into a drug treatment program can usually only anticipate a life without the drug, it could make the grieving process over the loss of their drug that more difficult.

According to Streifel and Servanty (2006), alcohol loss often includes other kinds of losses in correspondence to the loss of the drug itself. Drinking-related losses may include a loss of identity, way of life, friends, patterns, and hangouts along with the attachment loss of the alcohol itself (Flores, 2001; Streifel & Servaty-Seib, 2006). Other common grief responses to alcohol loss include preoccupation with alcohol-related thoughts, painful repetitive ruminations of drinking and drinking experiences,

and making sense of completely giving alcohol up. Pittman and colleagues (2007) explains that withdrawal symptoms from those who misuse alcohol include sleep disturbances, poor appetite, depression, alcohol craving, headaches, irritation, and dysphoria. Anxiety, withdrawal phobic symptoms, panic-related symptoms, grief over the loss of another person, stigmatization, major depression, and abnormal grief reactions have also been seen as symptoms of alcohol withdrawal (Blankfield, 1986). Other symptoms of alcohol withdrawal that have been noted include pathological mourning over object loss, loss of love, longing, neediness, guilt, malignant affect, and sadistic love (Miller, 1994) as well as anger, aggression, perceptions alteration, and psychomotor skill difficulties (Williamson, 2001). Many of these same reactions have also been seen in individuals grieving the death of a loved one (Worden, 2009).

2.3 Drug related death

The subject of overdose deaths appears to attract substantial attention among the public at large and from the epidemiologists, surprisingly it has sparked scant interest among researchers. Little has appeared in print on this neglected subject in the research journals (Feigelman, Jordan and Gorman 2011).

Mortality among injecting drug users in Chennai, India conducted by Solomon S.S., Celentano D.D, Srikrishnan between 2005 and 2008 highlights the connection between Injecting Drug Use and mortality rates. *Injecting drug users (IDUs) have estimated mortality rates over 10 times higher than the general population; much of this excess mortality is HIV associated.* Few mortality estimates among IDUs from developing countries, including India, exist. IDUs (1158) were recruited in Chennai from April 2005 to May 2006; 293 were HIV positive. Information on deaths and causes was obtained through outreach workers and family/network members. Substantial mortality was observed in this cohort with the highest rates among HIV-positive IDUs with CD4 cells less than 350. Although in these 2 years, non-AIDS deaths outnumbered AIDS-related deaths, the relative contribution of AIDS-associated mortality is likely to increase with advancing HIV disease progression. These data reinforce the need for interventions to reduce the harms associated with drug use and increase HAART access among IDUs in Chennai.

A Study conducted by Coffin in New York City investigated the contribution of multiple drug combinations to overdose mortality trends. *Accidental drug overdose*

contributes substantially to mortality among drug users. Multi-drug use has been documented as a key risk factor in overdose and overdose mortality in several studies. The data was collected on all overdose deaths in New York City between 1990 and 1998 using records from the Office of the Chief Medical Examiner (OCME). The data was standardized yearly overdose death rates by age, sex and race to the 1990 census population for NYC to enable comparability between years relevant to this analysis. Opiates, cocaine and alcohol were the three drugs most commonly attributed as the cause of accidental overdose death by the OCME, accounting for 97.6% of all deaths; 57.8% of those deaths were attributed to two or more of these three drugs in combination. Accidental overdose deaths increased in 1990–93 and subsequently declined slightly in 1993–98. Changes in the rate of multi-drug combination deaths accounted for most of the change in overdose death rates, whereas single drug overdose death rates remained relatively stable. Trends in accidental overdose death rates within gender and racial/ethnic strata varied by drug combination suggesting different patterns of multi-drug use among different subpopulations. These data suggest that interventions to prevent accidental overdose mortality should address the use of drugs such as heroin, cocaine and alcohol in combination.

Farrell M, Marsden J. investigates drug-related deaths among newly released prisoners in England and Wales. Database linkage study was adopted as the research design. National sample of 48 771 male and female sentenced prisoners released during 1998–2000 with all recorded deaths included to November 2003 There were 442 recorded deaths, of which 261 (59%) were drug-related. In the year following index release, the drug-related mortality rate was 5.2 per 1000 among men and 5.9 per 1000 among women. All-cause mortality in the first and second weeks following release for men was 37 and 26 deaths per 1000 per annum, respectively (95% of which were drug-related). There were 47 and 38 deaths per 1000 per annum, respectively, among women, all of which were drug-related. In the first year after prison release, there were 342 male deaths (45.8 were expected in the general population) and there were 100 female deaths (8.3 expected in the general population). Drug-related deaths were attributed mainly to substance use disorders and drug overdose. Coronial records cited the involvement of opioids in 95% of deaths, benzodiazepines in 20%, cocaine in 14% and tricyclic antidepressants in 10%. Drug-related deaths among men were more likely to involve heroin and deaths among

women were more likely to involve benzodiazepines, cocaine and tricyclic antidepressants. Newly released male and female prisoners are at acute risk of drug-related death. Appropriate prevention measures include overdose awareness education, opioid maintenance pharmacotherapy, planned referral to community-based treatment services and a community overdose-response using opioid antagonists.

The Scottish Naloxone Programme is currently implemented through specialist drug services, which aims to reduce Scotland's high number of drug-related deaths. General Practitioners are likely to have contact with drug using patients. The research gathered baseline data on GP's knowledge of and willingness to be involved in DRD prevention, including naloxone administration, prior to the implementation of primary care based delivery. Mixed methods were used comprising a quantitative, postal survey and qualitative telephone interviews. A response rate of 55% (240/439) was achieved. There was poor awareness of the Scottish National Naloxone Programme in participants. Results indicated GPs did not currently feel sufficiently skilled or knowledgeable to be involved in naloxone provision. Appropriate training was identified as a key requirement (Matheson, Pflanz-Sinclair, Aucott, Wilson, Watson, Malloy, Dickie, Mcauley, 2014).

While most major causes of preventable death are declining, drugs are an exception. The death toll has doubled in the last decade, now claiming a life every fourteen minutes. When someone has died in this manner a range of emotions and physical sensations are likely to be experienced. As well as shock and numbness, this can include sadness, anger, guilt, relief, despair and fear (Scottish National Forum on Drug Related Deaths, 2008).

2.4 Grief and bereavement

An explanation of grief: Research has shown that most people recover from uncomplicated grief without the need of any outside help (Worden, 2009). Uncomplicated grief is any normal physical, emotional, behavioral, cognitive, or spiritual reaction that occurs in response to a loss. While there are many similarities in the experiences of those who are grieving, most experts would agree that since there are a wide range of grief symptoms, grief is experienced differently by each person. Feelings associated with grief include: sadness, anger, guilt, anxiety, loneliness,

fatigue, helplessness, shock, yearning, emancipation, relief, and numbness. Physical sensation associated with grief include hollowness in the stomach, tightness in the chest, tightness in the throat, oversensitivity to noise, a sense of depersonalization, breathlessness, muscle weakness, lack of energy, and dry mouth. Cognitive responses associated with grief include disbelief, confusion, preoccupation, sense of presence, and hallucinations. Behaviours associated with grief include sleep disturbances, appetite disturbances, absentmindedness, social withdrawal, dreams of the deceased, avoiding reminders of deceased, searching or calling out, sighing, hyperactivity, and crying. Uncomplicated grief generally happens when these feelings, cognitions, or behaviors are or become chronic, delayed, exaggerated, or masked (Worden, 2009).

Theories of death-related grief and loss: According to Worden (2009), grief is defined as the feelings, behaviors, and cognitions that occur in response to a loss. Harvey (1996) noted that a loss can be something material, personal, or symbolic. In other words, according to these theorists, you can experience grief from the loss of many different things or people. Jerga, Shaver, and Wilkinson (2011) reported that the stronger our attachment is to something or someone, the greater our grief is when that person or thing is gone. Bowlby (1969) explains that we build attachments with other people or things in an effort to feel safe and secure. According to Worden (2009), a loss may violate feelings of safety and security. Even in death-related loss, Worden explains that grief is not always associated with the loss of the person themselves, but may be for the loss of time, memories, or other objects or places related to that person.

Feigelman, W., Jordan R, J,. Gorman, S and Bernard study parental grief in deaths related to drugs in research that began in 2005 where data was collected between March 2006 and July 2007. This comparative survey contrasted 571 parents who lost children to various death causes National Center of Health Statistics, U.S. Standard Death Certificate): 48 to drug-related deaths and overdoses, 462 to suicide, 24 to natural death cases, and 37 to mostly accidental death cases.

The groups were compared in terms of grief difficulties, mental health problems, posttraumatic stress, and stigmatization. The results did not show any appreciable differences in these respects between the suicide bereaved parents and those losing children to drug-related deaths. *However, when the suicide and drug-*

related death survivors were specifically contrasted against accidental and natural death loss cases, a consistent pattern emerged showing the former group was consistently more troubled by grief and mental health problems than the latter two sub-groups. These findings suggest that the powerful and intense stigma against drug use and mental illness, shared among the public-at-large, imposes challenges in healing of immense proportion for these parents as they find less compassionate responses from their significant others, following their losses.

Bailley, S.E.,Dunham K., Kral J. Michael conducted a study on a sample that consisted of 350 introductory psychology students at a major eastern Canadian University who reported having been previously bereaved. Participants were predominantly women (74%). The Grief Experience Questionnaire was administered as part a larger study on the effects of mode of death on grief reactions. The Texas Revised Inventory of Grief was used on which participants were asked to rate their closeness to the deceased. The factor structure obtained in this investigation documents that the GEQ is a multidimensional scale tapping into various dimensions of grief. The reliable assessment of grief reactions is clearly an important enterprise, not only in research-based efforts but also in clinical settings. In the clinical realm, professionals often find themselves working with bereaved individuals, and interventions used with such persons may focus on various aspects of their grief.

Bereavement-induced grief and psychological intervention are important social issues and worthy of greater attention from researchers and clinicians Psychological assessment of grief in general measures several aspects of internal reaction, such as sadness, searching for the deceased, crying, and yearning. Some instruments measure behavioral elements when subjects are confronted with bereavement and overcome grief, such as coping with death and readjustment to life. The best-known measures of grief in general are the Texas Inventory of Grief (TIG), the Grief Experience Inventory (GEI), and the Grief Measurement Scale (GMS).

Although considerable effort has been devoted to measuring the symptoms of grief, the main drawback of currently available instruments is the scarcity of psychometrical validity studies. At present, there are few standardized devices with which to assess the phenomena of grief, in either clinical or research settings. It is necessary not only to develop valid and reliable grief measures that can assess

multidimensional facets of grief along with its content, but to carry out comprehensive etiological research to examine the impact of grief during bereavement on health; for example, on the onset of psychiatric disorder (e.g., depressive illness), physical disease (e.g., cancer), and physiological changes (e.g., immunological change).

Feigelman, Jordan and Gorman conducted a study to explore associations between differing death circumstances and the course of bereavement among a sample of 540 bereaved parents. Comparisons were made between parents whose children died by suicide (n = 462), those losing children from other traumatic death circumstances (n = 54), and others whose children died from natural causes (n = 24). Results were mixed, showing suicide survivors with more grief difficulties and other mental health problems on some criteria, though most findings showed no substantive differences between these subgroups. Results also showed, in the first years after loss, repeated suicide attempts and prior negative relationships with the decedent were associated with greater grief difficulties. However, as more time passed, all death circumstance differences were overshadowed by the importance of the time span since loss. This data also suggested that between 3 and 5 years usually marks the turning point, when acute grief difficulties accompanying a suicide loss begin to subside.

In their study William Feigelman, John Jordan, and Bernard Gorman on Parental Grief after a Childs Drug Death made some interesting conclusions:

- Higher problems were reported for a drug and suicide bereaved death in comparison to an accidental or natural death.
- Drug-death bereaved heard more child and parent blaming comments.
- Evidence suggests that parents who lose a child to a drug-related or overdose death encountered much the same stigmatization and exclusionary treatment that suicide survivors confront.
- Greater grief and mental health difficulties comparatively to accidental and natural cause deaths.
- Close to half of the drug and suicide bereaved parents encountered blaming responses from their significant other.

Grief treatment: Four of the most common forms of treatment for uncomplicated grief are the stage model, phase model, task model, and dual-processing model (Worden, 2009). The stage model of treatment posits that people go through grief from one stage to the next in a linear fashion. The most common stage model of grief is Kubler-Ross's (1969) stages of dying, which include: denial, anger, bargaining, depression, and acceptance (Worden, 2009). The phase model posits that people go through various phases in the mourning process. For example, Sanders (1999) concludes that the bereaved go through five phases: shock, awareness of loss, conservation withdrawal, healing, and renewal. In contrast, Worden's task model puts emphasis on what others can do for the bereaved, in a more active form of grieving. Worden describes four tasks of grieving: accept the reality of the loss, process the pain of grief, adjust to a world without the deceased, and finding an enduring connection with the deceased in the midst of embarking on a new life. Finally, one of the more recent grief and loss model is the dual-process model, where Stroeb, Schut, and Stroebe (2005) posit that individuals vacillate between loss orientation and restoration orientation while grieving. In loss orientation, the person is focused on grief work, or processing the grief. In restoration orientation, the person is focused on things such as skill mastery, identity change, and other psychosocial skills to help them moved through the grief. For all of these models, grief treatment can be done in individual, couple, family, or group formats (Worden, 2009).

2.5 Coping and Social Support

The subject of overdose deaths appears to attract substantial attention among the public at large and from the epidemiologists, surprisingly it has sparked scant interest among researchers. Little has appeared in print on this neglected subject in the research journals (Feigelman, Jordan and Gorman 2011).

Persons who have lost a loved one through addiction know that society treats that death in a much different manner than a death from any other cause and it creates unique bereavement needs. Although many parents struggle with the challenges of losing a child to a drug related deaths, it is surprising and troubling that so little research has been devoted to identifying the unique bereavement needs of this large under-served population (Scottish National Treatment Agency, 2010).

When someone has died in this manner a range of emotions and physical sensations are likely to be experienced. As well as shock and numbness, this can include sadness, anger, guilt, relief, despair and fear (Scottish National Forum on Drug Related Deaths, 2008).

Grieving related to sudden and unexpected death, including bereavement related to suicide, homicide and other drug related deaths could be particularly difficult for family members and friends. The shock of the loss and the nature of the loss can result in anger, guilt, shame, rejection and abandonment. These kinds of losses make grieving particularly difficult and it is important for those providing support to appreciate the strong feelings and high levels pain that are associated with unexpected and unnatural deaths (Scottish National Forum on Drug Related Deaths, 2008).

Vitebsky P examines the differing emotional price paid for the disengagement by two young people whom the author has known since 1975, as one becomes a Christian and the other a shaman. Their struggles to be or to become a certain kind of person are revealed through recent extraordinary moments, precipitated by the author's presence, when verbal articulacy fails them. Their conflicts between filial attachment and repudiation, or shamanic vocation and recantation, are explored to show how changes in loving and forgetting can be revealed through new but fleeting forms of inarticulacy.

2.6 Methodology used in qualitative study on drug related death

2.6.1 Grounded theory approach

This approach is appropriate since limited research has been done on the 'grief and bereavement due to drug related death'. While there are many grounded theory approaches, the approach taken by Corbin and Strauss (2008) was used. No hypothesis was tested, but rather, the data was gathered and then analyzed to produce themes representing similar concepts. From these concepts, workable categories were created which formed the basis of the results. The grounded theory approach uses a systematic way of sampling and analyzing data until a theory emerges (Corbin & Strauss, 2008). Worden's (2009) tasks of grief were used as a guiding framework for

the interview questions and were used in analyzing and organizing the data in the result section.

2.6.2 Case study

According to Yin, case study research is more than simply conducting research on a single individual or situation. This approach has the potential to deal with simple through complex situations. This type of case study is used to explore those situations in which the intervention being evaluated has no clear, single set of outcomes.

There are two key approaches that guide case study methodology; one proposed by Robert Stake and the second by Robert Yin. Both seek to ensure that the topic of interest is well explored, and that the essence of the phenomenon is revealed, both base their approach to case study on a constructivist paradigm. Yin describes how multiple case studies can be used to either, (a) predicts similar results (a literal replication) or (b) predicts contrasting results but for predictable reasons (a theoretical replication) (In Baxter& Jack, 2008).

While most major causes of preventable death are declining, drugs are an exception. The death toll has doubled in the last decade, now claiming a life every fourteen minutes. When someone has died in this manner a range of emotions and physical sensations are likely to be experienced. As well as shock and numbness, this can include sadness, anger, guilt, relief, despair and fear (Scottish National Forum on Drug Related Deaths, 2008).

2.7 Theoretical Framework

Theories provide conceptual understanding to complex problems or social issues such as grief and loss (Reeves et al., 2008). Three of the most prominent theories in the field of grief and loss are attachment theory, continuing bonds, and Worden's task theory (Rothaupt & Becker, 2007). These theories have only been used to compare the grieving process of those experiencing a death-related loss. These theories will be triangulated to inform the study.

Theories of grief and loss:

Attachment theory: Attachment theory is a theory developed by Bowlby (1969) in which he posits that humans strive to develop strong affectional bonds with others in order to feel secure and safe. Attachment theory also posits that conditions that endanger attachment bonds, such as a loss, may provoke strong grief-related reactions (Worden, 2009). William Worden (2009) conceptualized the concept of loss using the framework of attachment theory. Gervai (2009) noted that the greater the bond is, the greater the sense of loss is when that bond is broken. Most researchers suggest four types of attachment styles: secure attachment, anxious, avoidant, and disorganized (Gervai, 2009; Worden, 2009). Gervai's (2009) research demonstrated how those with secure attachment styles are less likely than those with anxious or avoidant attachment styles to experience complicated grief. Other studies have shown how attachment insecurity is a risk factor for more intense grief experiences (Jerga, Shaver, & Wilkinson, 2011) and how attachment style is associated with one's ability to recover from a loss (Worden, 2009) and effectively go through the mourning process (Jerga et al., 2011). Intense or complicated grief experiences may manifest itself in different ways, but is usually evident when there are prolonged, delayed, exaggerated, or masked grief reactions (Worden, 2009). Disorganized attachment, on the other hand, has been shown to invoke both positive and negative emotional reactions to loss (Judit, 2009). Disorganized attachment is most commonly demonstrated by role confusion, communication errors, extreme withdrawal, and signs of neediness toward caregiver (Gervai, 2009). While a majority of people do recover following a loss (Worden, 2009), an estimated 9% of bereaved people experience chronic grief after the death of a loved one (Jerga et al., 2011). Jerga and colleagues (2011) suggest that one's attachment style is influential in helping someone go through the mourning process without complicated grief. *Continuing bonds:* Recent research has suggested that attachment relationships are continuous and that relationships are not severed by death (Bell & Taylor, 2010; Worden, 2009). Under this premise, because we develop a continuous bond with those whom we love, it is suggested to not emotionally disengage from the deceased, but to help individuals form a secure base when grieving (Worden, 2009). In Steffen's and Coyle's (2008) study they demonstrate how meaning reconstruction and on-going attachment to a loved one has been used to improve bereavement outcomes, and that meaning-making

through relevant spiritual frameworks, such as continuing bonds, may lead to better coping along with post-traumatic growth. The authors add that continuing bonds with the deceased are usually described as a sense of presence, nearness, a connection, or intense warmth, which is difficult to describe with known senses. The theory of continuing bonds suggests that one's relationship with the deceased is continuous, and that one stays connected with them to some degree for years.

Worden's tasks of grief: Because William Worden (2009) has studied reactions to grief for over 30 years, his theory has given many a way for treating grief. Consequently, his theory of grief and loss will be used as a guiding framework for this study. According to Worden, there are four tasks of mourning: to accept the reality of the loss, to process the pain of grief, to adjust to a world without the deceased, and to find an enduring connection with the deceased in the midst of embarking on a new life. According to Worden, the first task is to help the individuals come to the full realization of the loss. Part of this process is coming to grips that reunion is not possible. The opposite of this task is some form of denial.

Worden's (2009) second task is to process the pain of grief. This includes physical, emotional, and behavioral pain that is associated with a loss. According to Worden, many people go out of their way to suppress such strong feelings. Also, many people hear statements about "getting over it," which may push people away from expressing their real emotions.

The third task of grieving, according to Worden (2009), is adjusting to the world without the deceased. This task includes both external and internal adjustments to not having that person around in your life as well as spiritual adjustments of how they view the world and why this has happened to them.

The fourth task to grieving is to find an enduring connection to the deceased in the midst of embarking on a new life (Worden, 2009). In this task, people do not need to give up their relationship with the person who has died, but needs to find an appropriate place for the deceased in their emotional life. According to Worden, this must take place in a healthy way so that individuals can move on effectively in a new world without their loved ones.

CHAPTER – 3

METHODOLOGY

3.1 Profile of the study

The problem of substance abuse and addiction has become a threat all over the world including Mizoram. The common drugs of abuse in Mizoram are dendrite, sedative pills, cocaine, LSD, Ganja, Nitrozepam, Heroin, Spasmoproxyvon, Parvonspas, Letane, Nitrovet, Codeine, Pethidine, Fortwin, Cough Syrup, and Alcohol (Mizoram Social Defence & Rehabilitation Centre, 2005).

Cannabis is one of the commonly abused drugs, because of its availability and low cost factor. Heroin users are mostly from higher socio-economic background; probably due to its high cost factor. Reduced availability of any drugs often results in emergence of newer drugs. Spasmoproxyvon became the most widely abused drugs after heroin, probably due to higher cost of heroin and its erratic supply chain. Other drugs like Cough syrup containing codeine and prescription drugs are often abused for recreational purposes; users are mostly females. In the last 3 - 4 years, a younger population groups commonly abuse prescription drugs, (Chawnglungmuana, 2012).

Mortality related to abuse of drugs is increasing even in Mizoram. The data from the database of Excise and Narcotics Department, Govt. of Mizoram shows that the first case of overdose death recorded was in 1984 due to *heroin with a* total case of overdose death recorded till date as *1269*. This figure does not include the cases in which overdose deaths reported as accidental deaths such as heart attack or other drug related illnesses. It is, however, common knowledge that there are many drug-related deaths that occur in Mizoram, there is under-reporting and lack of acknowledgement of cause during death. This however also translates into the fact there are few services available for coping with the bereavement. Support groups for bereaved families are nonexistent and in many cases, the families try to hide the fact that they have a substance abuser in the family.

This study will attempt to profile the characteristics of drug-related deaths that have occurred and explore the causes that have lead to substance abuse related deaths. It will attempt to understand the lived experiences of grief and bereavement in relation to drug-related deaths and identify the coping mechanisms used by the family members and study the availability of the support systems for families bereaved due to such deaths.

3.2 Pilot Study

A pilot study was conducted from the 28th October 2013 to 16th November 2013. A total of 17 days of fieldwork was put in and objectives were laid down in order to have a more systematic and thorough study on the topic. (see Appendix - A)

The topic for the fieldwork is "Exploring the grief pattern of families bereaved due drug overdose".

The **objectives** of the pilot study were:-

a) To understand the issues related to grief and bereavement.
b) To find out the causes and consequences of overdosed deaths.
c) To identify and study the impact of overdose deaths on the families.
d) To study the availability of the support systems for families bereaved.

These objectives were drawn in order to gain knowledge and understanding and gather information to help and add validated data with regards to the topic.

The methodology employed in the fieldwork included case study, participatory rural appraisal techniques, focus group discussion and interview in order to understand the situation of bereaved families.

From the pilot study, the various issues relating to grief and bereavement were identified which includes physical, psychological and sociological symptoms. The causes of overdose deaths were addiction, intravenous drug use, unavailability of quick medical response, mixing of different kinds of substances (drugs and alcohol) and ignorance of adverse affects of narcotic drugs while the consequences of overdose deaths were shock/trauma, social stigma, anger, helplessness, guilt and shame in the families, depression and anxiety.

3.3 Methodology

This study covered aspects related to grief and bereavement in drug-related deaths in Aizawl, This study is exploratory in design and cross-sectional in nature. The number of cases of drug-related deaths registered in Mizoram is not very reliable and often there is under-reporting of deaths due to the fact that there is unreliable data. The issue of bereavement in general and in particular for drug-related deaths is very sensitive; hence the methodology used in this study further lent itself well to

qualitative approaches. Since this is a qualitative study based on individual experiences, participants were selected using systematic sampling. A case study design was adopted to conduct the study and multiple case studies were used in design.

Flyers were created about participation in the study and given to the key informants in the community to distribute to the bereaved families. For the purpose of this study, bereaved families included those who had experienced a drug related death between 2007 and 2013 June. The interview process began when participants reported back to the key informants. (see Appendix B)

3.4 Sources of Data

Primary data was collected from case study, key informants interview and focus group discussion.

Secondary data was collected from relevant literatures from Mizoram Excise and Narcotics Department and NGO records were used wherever applicable.

3.5 Sampling

Multi-stage Sampling was adopted. In the first stage, Aizawl was purposively selected due to the fact that it records the highest records HIV/AIDS (MSACS) related deaths in Mizoram. In the next stage, three urban localities with highest drug related deaths in the stipulated timeframe were selected from the Mizoram Excise and Narcotic Deptt. (Drug Related death (Year-wise) w.e.f 1984).

In the third stage of sampling, a final sample was selected using proportionate sampling to keep gender and the localities represented. The family members of the identified families were contacted. Consent was sought for the study after the purpose of the study was explained and one or more family member each (spouse/parent/sibling or adult son or daughter of deceased member) were interviewed based on their voluntary participation. In all, a total of 20 in-depth interviews were conducted for the five case studies that are presented. In addition key informant interviews were conducted with (designations) to augment the data and understand the nature of reality surrounding drug related deaths in Mizoram.

3.6 Tools of data Collection

3.6.1 Guide for Case Studies

A guide which was constructed to develop a profile of drug-related deaths, document family particulars, nature of death, and history of bereavement, coping and social support. Help was sought from Texas Revised Inventory of Grief (TRIG) by Faschingbauer, 1981 to guide the issues to be raised. (see Appendix - C)

3.6.2 Guide for Key informant Interviews

Key Informant Interview guide was constructed to collect information on bereavement and rituals associated with death from church elders, community leaders, government functionaries and personnel from non-governmental organizations. The data collected from such interviews helped understand perceptions of service providers and community leaders related to drug deaths caused by use of drugs. (see Appendix – D)

3.6.3 Guide for Focus group discussion

The focus group discussion guide was prepared with the help of The Grief Experience Questionnaire (GEQ: T.W. Barrett & T.B. Scott, 1989). The GEQ is a multi dimensional scale tapping into various dimensions of grief. It assesses grief reactions that are potentially problematic after any mode of death.

The discussion was framed within the context of eight factors containing fifty five sub topics that indicates abandonment/rejection, stigmatization, and search for explanation, guilt, somatic reaction, responsibility, self-destructive orientation and shame/embarrassment.

The discussion was held with a purposively drawn sample of parents, siblings and spouses representing bereaved families in drug-related deaths. (see Appendix - E)

3.6.4 Ethical Aspects and Process

Five case studies were conducted to understand the lived experiences of grief and bereavement in relation to drug-related deaths and to identify the coping mechanisms practiced by the family members. One or more family members were

interviewed for one case. The cases are presented in narrative manner in first person account. The case studies are titled *The Weeping Widow, The Praying Mother, The One That Loves, Father of One and Brothers. T*his renaming lends itself better to the narrative used and protects identity

On the day of the interview, the scholar met the volunteers in the respective places as discussed and selected by the volunteers.

The interview began by introduction from the scholar and explanation of the purpose of the study. After that the informed consent forms were reviewed they were asked if it was okay to digitally record the interview, the interview recorded for transcript accuracy. For the participants who opted out of the recording, brief notes were taken and they were asked permission to be quoted on significant information discussed.

Since this interview was an open-ended interview, an interview guide was used to guide the interview. The scholar occasionally deviated from the script to ask other pertinent questions or for clarifications. Interviews ranged from twenty to forty minutes in length, depending on how the participants chose to elaborate on the questions and the speed at which they spoke. In several cases more than one interview per person was held to augment the data.

Each interview was ended by thanking the participants for their time and debriefing with them about how the interview was for them and if they were having any difficult or uncomfortable feelings. The scholar reminded each of them to please contact her if any difficult feelings or thoughts persisted.

3.6.5 Data processing and analysis

The recorded data was transcribed and was processed manually. Case studies, reports of Focus Group Discussion as well as Key Informant Interview have been formulated for the final report. Themes were identified and developed.

CHAPTER – 4

RESULTS AND FINDINGS

4. Results and Findings

Results from the study are presented within this chapter and the findings are interpreted in relation to relevant and available literature.

The results are presented in three sections.

Section I: Case Studies 1-5

Section II: Focus Group Discussion

Section III: Key Informant Interviews

4.1 Section I - Case Study

4.1.1 Case presentation of "The Weeping Widow" (see Appendix – F for Mizo Version):

The Weeping Widow

I was married to my husband, Peter when we were both very young. He was a year older than me and I was barely eighteen, I was four months pregnant when we were married.

The story of our courtship was rather dramatic to say the least. We met almost two years before we were married at a birthday event of a mutual friend. He came and spoke to me and we immediately clicked. My first impression of him was that he was witty, easy to talk to and had a good sense of humor. Since there were no mobile phones at that time he would call me up at our landline and we could talk for a couple of minutes, being careful for my parents not to find out since they are rather conservative. After about a week of knowing him I invited him to come over at our house. (This is a common practice in Mizo Society, traditionally called *in rim* where the guy would go over to the girl's house in the evening after dinner to sit and talk a courtship practice with the acknowledgement of the girl's parents). On his first visit he was very shy and talked very little, and he stayed for well over an hour before he headed home. I had asked him to come again the following night to which he showed up. To my surprise, he seem to be a little at ease and was rather talkative and was like himself the first time I met him at the party. We sit and chatted, watched some

television and he even had a conversation with my parents while I was making them tea in the kitchen.

After this went on for a few months, I grew fonder of him as he was very caring. Although I knew he drank alcohol the night I first met him at the birthday party, the possibility of him being a drug abuser never crossed my mind until an incident with my mother. One evening as I went home from school, I told my mother that I was going out to have dinner with Peter and his friends to which she said I must be careful and should not do anything that isn't good for me. I remember questioning her and I was a little upset that she would think Peter doesn't take good care of me. My mother then said that he seems intoxicated some nights when he came over and that she had noticed he doesn't smell of alcohol. I brushed off her comments and told her that she is probably mistaken and paranoid.

That night at the dinner party, what my mother said to me kept repeating in my mind, I thought back on the first night he came over and how shy he was and how it all seem to disappear the following nights. I became a little bit more attentive towards him that night as he was among his friends, he did not seem to be drinking a lot, and I noticed a couple of his friends seem like Injecting drug users since their hands were swollen. I was in the kitchen preparing dinner with some of our friends while I lost track of where Peter went. It was not until dinner that I saw him again and he seems to have changed in between, he laughed more and seems more "loose" after that, and at that moment I began to have a striking fear of the possibility of my mother being right. After dinner, he dropped me off to our house and on our way home I confronted him about what happened, and asked him if he uses drugs. He just nodded hesitantly and said he has been trying out for a very short time. He tried to explain and said that he only tries them out at parties and will stop if I want him to. I was convinced when he said that if it is something I disapprove of, he would immediately stop.

A few months went by and we were very happy, however, my parents seem to think that us being together was a bad idea. My mother was convinced that he was a bad influence to me and my father did not want him coming around to our house. We'd meet after schools and he would pick me up with his bike and we'd visit our friends. I felt that my parents did not want me to be with him and that they did not want me happy, so I confided in him, I trusted him and he made me feel safe. He

would also confide in me, he said that he felt hurt and wronged by my parents disapproving our relationship, and that he was very unhappy with his family. He would tell me that his father is an alcoholic and would drink from morning to night, and his mother never said anything about his father's drinking. He has a younger sister who was still in school and it is up to him to take care of them when his father is not around anymore. He used to tell me that his father was abusive to him and his mother, and his sister was in a boarding school. He felt responsible for their safety and that protecting them from his drunken father was his duty, he was under a lot of stress and he would use that as an excuse to get drunk on some occasions. On some occasions he said that he wants to get high to forget the pain and I would let him, by not confronting him when he was drunk. I felt partly responsible, thinking back, for his habits because in the beginning when he said he was only drinking, I'd believe him, even though I was suspicious that he was taking drugs. I didn't want to be alone without him and I did not want to lose him, and I was afraid that would happen if I accuse him of using drugs. What if I ask him? What if I am wrong.....Will I hurt him more for doubting him? And what if I am right and he does use drugs...that will mean that my mother was right and they (my family) would never let me be with him. All those questions were in my head for well over 3 months but I never had the courage to ask him, but I had to know because it has been 19 months since we first met, and I had gone to the doctor a week earlier to learn that I was two months pregnant with his child.

One evening as he came to my house, I remember being terrified and nervous, I guess he sensed that and asked me what was wrong. All that could come out of my mouth was *"I'm having your child"*. He seems to be confused and asked me again and I replied *"I'm pregnant"*. He seems surprised and happy, and at the same time, worried. He said that I being pregnant was a good thing because that might change my parents' mind about him and that we could get married with their blessings. I was surprised by his reactions, and how my parents' approval means so much to him. And when he mentioned getting married, part of me felt safe and loved, the realization that he, wanting to settle down to build his own family with me was overwhelming. But in reality we were just a couple of teenagers who met and fell in love, both still in schools and thinking about the future with an unplanned baby seems a little too much.

We had nothing figured out yet, no wedding plans, no family plans, no financial plans and we haven't even come up with how we were going to tell our parents.

The following day Peter picked me up after school and pulled me away from my friends, who were walking next to me, I asked him what had happened and he said that he had a plan. He suggested that we elope that night after dark, we have thought about this before. Since my parents were rather disapproving of our relationship, we'd often joke that we would elope if they won't let us be together, but never went through with it because we never had any reasons to. But ever since I learnt that I was pregnant, it seems like eloping with him is the only thing that makes sense. I have heard of many people who got married after they eloped. When the family interferes in their relationships and disapprove of their courtship, they would elope and their families will have no other choice but to accept them, and that was the plan for us, if we had a good excuse for our families to not take us away, and the baby on the way seems like the perfect excuse to convince our parents to bless out marriage. So when he mentioned eloping, I was rather happy. We made a plan that I would go home, pack my things without my families knowing and Peter would wait out for me at the tuck shop not far from our house and I would join him as soon as my parents sleep, which was usually around 9:00 PM. And just like we had planned, that night I slowly opened the front door with a bag of clothes on my shoulder and walked towards the tuck shop to see Peter waiting for me there.

After the elopement and both our parents came into terms with our relationships and the reality of the situation, almost two months have passed and I was four months pregnant, they finally agreed on our marriage. We finally got married after which we lived with his parents and I dropped out of school, he began taking computer classes and we were beginning to face problems which we never saw coming. His father continues his drunken brawl almost every night and would throw fits on his wife and Peter. He was abusive and often said that his son got married and he had to take the responsibility of raising his family for him, with no income and no work, and would often told his son to leave the family because having him is only a dead weight for him and his mother. Peter was a kind man, he respected his father and even with his brawls, he would never say a word back to him. His mother would often tell her husband to stop yelling at their son and be an example. We would try to sleep through nights of fighting between Peter's parents, and one evening, as I was cooking

dinner, Peter's father came home drunk and started yelling at me. He accused me of trying to ruin their family, brainwashing his son and tricking him into marrying him. I was in tears when Peter came running out of the room, and for the first time I saw him standing up to his father. Peter told his father that he started drinking and uses drugs because of him and that having me in his life has helped him make better choices, which was hard for him because of the constant disapproval from him. Peter then took me to our room, packed my bags and asked me to stay with my parents for a while till he sort out his issues with his father, which would only take a couple of days, and he dropped me off that night to my parents'.

Days have passed and except for the phone calls from Peter, I had not seen him, every time I asked him when he was going to pick me up, he would tell me to wait a while. After staying at my parents' house for about two weeks, Peter finally came, and this time he was different. Very different from when I last saw him. He looked tired and he was very high. And this time, to make matters worse, I knew without a doubt he was on drugs because he was so high he could hardly stand, yet I did not smell anything on him. He had told me to go home with him; the taxi was waiting on the road so I knew I didn't have much time to decide. If I let him go home alone like that, I would be worried sick and if Peter's father says anything, that would be the time for me to step up for him, so I went inside to get my things and followed my husband home.

I could not say any of these to my family since my mother was still very disapproving to Peter and my father hardly ever says anything. Peter was using again, and this time it was not for recreation but to escape his reality. I did not know what to do and the baby was on the way. I was seven months along and there were nights when he would stay out all night because the moment he comes home, his drunken father would start belittling him, making him feel insignificant and worthless. It was too much to take for a nineteen year old man with a kid on the way, yet without a job or security for his family. Peter would often tell me that it was alright for me and the baby to stay with his parents as long as his father did not start anything, and he would try to stay with him as little as possible if that is the only way he can give me and the baby a safe home. Peter was determined to make himself useful around the house when he was home, he was good at fixing things and some of his friends would come by their house to have him fix their computers and bikes, for which they would pay

him. Often times he would go out with them and get high, but even when he does, he was never mean or abusive to anyone. After the birth of our child, Peter has saved enough money to buy a computer for him to work on. He said that he'll get his computer certificate and look for a regular job; he was very excited about it.

A few months passed and Peter got a job at a computer shop and began to work regularly. Although his pay was not much, it was enough to provide for his new born son. Peter's mother was overwhelmed at being a grandmother and she was very loving to me and my son. Peter's father was also approving of his grandson, although he was hardly around. Things seem to turn out better for our family after the baby came, except for Peter who found it hard to cope with his life without using drugs. It was of everyone in the family's understanding that Peter had become hooked to his drugs. He took pills like Diazepam and Nitrosun for about half a year after which he began injecting Parvon Spas.

Our son has almost turned three when Peter's mother, his sister and I decided to have an intervention. His mother confronted him, saying that we knew about his drug use and that it was unacceptable. He was very defensive, and told his mother that it was only for recreational use. However, his sister said to him that he knows the truth more than anything else and that it was time for him to clean himself up. His mother then said to Peter that his son will soon grow older and she would not want her grandson to grow up to a father who is an addict, and that Peter himself knows better. We each told him that if he decides to stay clean, we'll all do our part and give him the support that he needs.

As months passed, it was difficult for Peter to stay completely off the drugs since his withdrawal was too hard on him. We had come to the acceptance that drinking alcohol was better than taking hard drugs, so he drank. Soon after he became alcohol dependant and with his body already so weak from his previous drug use, the alcohol hit him hard on his health.

His drinking continues for a couple of years but somehow it was more manageable than his drugs use. He was no longer a regular user of drugs, or safer to say that drug use was not a threat to him anymore, but rather, his choice of substance was alcohol. However, being the kind of person that he was, he did not cause any problems for his family; he was never abusive or violent. He continued working all

the while, and the people he worked for were kind and understanding. He did the best he could, he made it his personal habit to never show up at work drunk, however, there were days when he would start drinking from morning, and on those days, he would ask me to call in sick for him.

A couple of years after that, we began to learn that Peter had started using drugs again. And this time, they were Alprazolam and cough syrup, all this while he was drinking too. The relationship with his father was once again estranged. The fights began and this time it was worse than before because Peter and his father were both high and neither of them would step down from their arguments. Sometimes their fights would even get physical and we'd have to pull them apart.

The following year, Peter was admitted into hospital for the first time. He had an internal bleeding among various other complications. The doctors said that it was due to his many years of taking pills orally that had given him a severe case of ulcer and that if his drugs and drinking habits continue, it could be fatal. He was released after his treatment was completed.

The hospital stay helped Peter stay away from his substances for well over 5 months after which he began using again. He found it difficult to stay sober, using the festive season of Christmas as an excuse. He would come home high, and sometimes he would stay out for nights. At that time it had become more of a habit for us, so we were not that worried. He would come home and stay as if nothing had happened, however, one of the most difficult things to deal with was our son asking for his father when he wasn't home and I did not know how to respond.

In the beginning of that following year, Peter was again admitted in the hospital due to internal bleeding. After getting treatment for six days, the doctors were ready to discharge him. On the morning of the discharge, I was at the hospital with Peter, waiting for the doctor come for his rounds where he will be signing the discharge papers and other formalities. Peter called home and spoke to our son, he was excited to tell him that he will be at home by the time he comes home from school and he'll bring him chocolates for him. Our son was just as excited as Peter was; perhaps it was because Peter loved him very much. He never raised his voice to his son and had always been patient with him; he would never forget to get something for his son when he goes out with friends or to work, even when he was high on drugs

or drunk, he'd get something for his son and was very careful to not let him see him drunk.

When the doctor came in to discharge Peter, he called us in to the nursing station and gave us instructions about his medications and mentioned that Peter's condition was very serious, and if he continues using drugs or drink alcohol, his body may not be able to handle it anymore since years of drug use and drinking have caused damage to his organs. It was a moment of clarity for the both of us.

It has been almost a month since he was discharged from the hospital, and one evening at dinner table, Peter's father was having one of his brawl and he was heavily drunk. He started with Peter being useless and began accusing him of the family's financial problems. He went on to say that if his wife (Peter's mother) had not given him money to buy drugs their son would never become an addict, and blamed me and Peter's mother for being so soft on him. Peter was furious with his father and stormed out of the house after words were exchanged between the two of them. I left our son with his grandmother and went out looking for him to his friends' houses that weren't far from our place. After searching for him for a while, I couldn't find him and went back home. I was worried that Peter would do something stupid and unimaginable, but I had no other choice but to wait. Just as I had put our son to sleep, Peter came home. I could see that he had been drinking but I did not want to upset him further so I didn't question him. He cleaned himself up and came to bed and before he slept, he told me that he was not upset with me or anyone else except his father. He said that if he could take us away, he would but then he would be worried about his mother and sister. I assured him that everything was going to be alright. At around 1:00 AM that night, I heard a loud thud coming from the bathroom and immediately woke up, I realized that Peter was out of bed so I rushed towards the bathroom, since it was not locked i pushed it open and I could see what had happened. Peter was lying on his back on the bathroom floor, gagging and his arms tied with an elastic band I had kept on the drawer to change our son's pajamas. I remember screaming for help as I knelt down next to Peter, keeping his head up on my lap. Our son was awake and crying when he heard me scream, and Peter's parents and his sister came rushing into our room. I was lost for words, I kept calling him as we carried him to the bedroom floor, he held my hands so tight I wasn't sure if he was awake or passing out. Peter's father went to wake the neighbors while his mother and I sat next to him, pumping his chest

and trying to keep him awake. I blew into his mouth because I felt it was the right thing to do. I was in shock and did not know any better, but for some reason I was hoping it would work. Our son was taken into the other room by his aunt and the neighbors soon arrived. We then carried Peter to the car and took him to the hospital. On the way, I sat next to him, he was leaning against me and I remember holding him. I don't think he was conscious anymore, but he held my hand so tight. About two minutes into the drive to the hospital, I felt his breath stopped and his hand began to feel soft and he had let go. I could not believe that and I started calling his name but he was not responding. Soon after we arrived at the hospital emergency, his mother and I were crying and the neighbors along with some people from the emergency brought a stretcher and took him out of the car. When we entered the emergency, the doctor came to me and told me that there was nothing they could do, and that he had died on the way to the hospital. He asked me what happened when I found him and told him what I saw. That was when it was concluded that Peter died of a drug overdose when injecting himself with a lethal dose of spasmoproxyvon.

I did not remember much after that till about three or four days later. The whole procession of his death and his funeral seems like a dream even when I think about it now. But what followed after was rather difficult. There are certain religious processions we had to follow, certain cultural practices that were carried out. The first two nights of his death we had youth members coming to our house to pay their condolences, and nights after the elders from the community would visit us. They are supportive and kind to us, saying that they would pray for our family. Peter's close friends would come over every now and then and would talk about him, reminding us of how good a man he was, as a father, a husband and even as a friend. Some of his friends would often blame Peter's father and they were angry at how badly he was treated by him. Most people who knew Peter did not blame him for his addiction; they remembered him as someone who loved his family and friends. I did not know who to turn to after Peter was gone. I felt that although he was given the funeral he deserved, with loved ones, friends and family and the community coming together, something was missing, perhaps it was Peter. I looked and saw that they had written the cause of death as Overdose, and every time I looked at it there's a rush of anger, helplessness and sympathy towards my husband. His cause of death is something completely different from the man I had known for so many years, and it felt like a lie. I thought

about all that he had been for me and our son, and dying of an overdose doesn't seem to do justice to his life as a loving father and caring husband. I was angry and felt that life was unfair to lose him so young when he had so much more to look forward to.

His friends talking about him and how much he had given for his family is still a story I love to hear even today, even years after his death. Sometimes it is still very hard to believe that he is gone. Part of me blames his father for being so hard on him and I also blame myself to much extent because I feel that if I had stood up for him in his fights with his father, he wouldn't feel so alone. I look at our son and it reminds me so much of his father, his interests and quick ability to learn computers. In everything he does, I see his similarities with his father, and I really wish that Peter is around to see him grow up.

It took me a long time to come into terms with what had happened. It was until months after that I came to accept that Peter had died. As the Christmas season was approaching, Peter's mother had bought some decorations and suggested that we decorate Peter's grave with a reed and put new paint. It was hard to accept in the beginning, and I cried for hours after coming home from his grave.

It has been almost nine years after his death, and his memory is one that I can never let go. Although I have come to terms with him being gone, I still hold on to his memories and try the best I can to impart the memory of his father to his son. I was only a young widow when Peter died. Many would think that it is wise to find another husband to help me raise my child and move on but I feel that I owe it to Peter and our son to give the life we had dreamed of when we were much younger. I now have a job to support my son and we are still living with his parents in the house where Peter passed away.

At times when I think about it, I blame Peter's father for Peter's death, however, I have understood him now better than I used to. His alcoholism has taken the best of him for so long that it becomes his nature so I have learned to live with that.

4.1.2 Case Presentation of "The Praying Mother" (see Appendix – G for Mizo Version):

The Praying Mother

My husband worked for the government and I tried to help out with generating income by running the government office canteen near my parents' house in the city while my husband was posted in rural areas. I was a mother of three children when my husband left me for another woman. I moved in with my parents and took my kids with me when it all happened. After the incident, I was determined to build myself a thick skin and wanted to stand on my feet and not be dependent on anyone. My eldest son, Robert was eleven years old at the time and had just started middle school and his younger sister was nine, the youngest was five years old and had just started school.

My parents lived with my youngest brother at our childhood home when we joined them; they have been running a grocery shop which was their main source of income. Our business grew it was one of the biggest grocery shop in the community. Our community was mostly of migrants who had moved into the city from rural areas of Mizoram. So it was common for us to see new faces every now and then who had just settled in. Three years have passed since my divorce and Robert had turned fourteen, he was a sweet kid and would help out in the shop during holidays with his sister. Since he was the oldest among the kids, he was very responsible and protective of his younger brother and sister. The kids in his school would tease him that he had to work during holidays instead of playing with them in the local football ground. He would tell them off by saying that he was a grown up and did not have time to play with kids.

Around this time, the use of drugs was a new trend among many youngsters. We have heard that many migrants from our community were drug pushers and as a result to this, some of the young boys from the community have also started using drugs. It was a bleak transitional period as I recall, and Robert had just turned 14. As any young boy would, he began hanging out with boys his age and sometimes I felt bad to keep him at home and help us around the house so I used to tell him to go out and play with his friends. It did not take long for him to make new friends, and by the end of that year, I noticed that his behavior has changed. People have been telling me

that they saw Robert and his friends hanging around by the playground and smoking cigarettes. When he came home one evening, I asked him where he have been and he replied that he was with his friends by the playground, that was when I told him that people mentioned him smoking with his friends, he did not responded so I figured he did not want to admit to the truth. I told him that it was unacceptable for a child to smoke, and him being the eldest son, should take the responsibility to set example for his brother and sister.

The following week, he was back with his friends and they came by to ask for my permission to let him play for the local football tournament, which I let him under the condition that they promised to stay out of trouble. They were a bunch of children who were on school holidays and looking to have some fun with the time they had, so I figured it would be good.

One evening, Robert did not come home in time for dinner, which was unusual because every evening our family would have a devotional service before meal and he would never miss that. We waited for him for a while but he did not come home so his uncle suggested that maybe they were running a little late with their practice and that we should start without him. A little while after dinner, he came home. He looked tired and went straight to bed and slept.

A couple of years passed as Robert seem to find a new interest in football, he would go out almost every evening after school to practice with his friends, and as time goes by, it was apparent that Robert has shown some change of behaviour. He did not spend as much time with his brother and sister and often looked for excuses to go out with his friends. He hardly helped out in the shop anymore. As any mother would, I was slightly worried that something was wrong with him, but then I pushed that thought aside, telling myself that he was in an awkward stage of growing up and was just trying to find his path.

It was in 1995 that I first heard rumors about Robert using drugs. It was of concern even before that since a large amount of youngsters his age have started injecting themselves, but I always thought that my son would be responsible enough to stay away from it. When the rumors first started, I was angry and confused, but my parents and brother were supportive of my decision to confront Robert.

One evening as he came home for dinner, at the family devotion, my father stood up and said that we have heard some rumors about Robert using drugs, and that such behavior was unacceptable to our family. Robert was angry at first and was apprehensive about the confrontation and even denied ever using drugs. Not more than a week later, as I was cleaning the house and doing laundry, I noticed a small plastic bag that fell from one of Robert's jeans that he had worn the day before. I picked it up and looked into it – just as I had feared, there was a used syringe, a bottle cap and an empty capsule of Spasmo Proxyvon in the bag. It was clear for me right then that my son was an injecting drug user, otherwise, the bag that fell from his pants have no business to be in his possession. I went to my brother with the bag and told him what had happened; he said that he and I should talk to Robert about it and that it would be wise to have a body inspection, to see if there were any needle marks on his body and if there is, he will have to come clean and tell the truth.

That night, my brother and I went to Robert's room which he shared with his younger brother. His uncle placed the plastic bag on his desk and demanded an explanation from him, asking him if he knows what was inside the bag and if it belonged to him. Robert denied ever seeing the bag and said that he had no idea what was in it. I then said that I found it as it fell from one of his pants while I was doing the laundry, and Robert remained quiet after that. My brother then said that he would like to check Robert for any needle mark on his body, and started to do so. Part of me wished that what Robert had told us was true, and that his uncle would not find any needle marks on him, and as I prayed silently and waited, my brother called me and asked me to see what he found. There were several needle marks on his groin area, and at that point Robert could no longer lie. I was full of questions...when did it all started, how long has this been going on, how did he start, why did he do it.

It was difficult to wrap my head around the fact that my 16 year old son, who just a couple of years ago, was just a kid running around the shop helping us, has become an addict. I remember praying for him after that, asking forgiveness for him and for myself. I felt that I had failed as a mother and wanted to make it right. It turns out that Robert would steal money from the shop and used it to buy the drugs and share it with his friends. And our community being a small one works to our disadvantage when Robert was expelled from school and was no longer allowed an admission because of his addiction. It had become a full time job for me to guard my

son even while he was at home, and I had to make sure he did not go out because I was afraid he might run away and put himself in danger.

As Robert's addiction became more problematic and I was running out of options, my younger sister who was married and stayed at her husband's post in rural area offered to take Robert with her. We figured it was a good idea because it was impossible to find the substances in rural areas and it might be a good thing for him to stay there, so Robert stayed with his aunt that year.

After being clean for over a year, Robert finally came home, but relapsed soon after. We did everything any family could have done to help one abstain from drugs. We sent him to rehabilitation centres in other States, kept him in faith based organizations here in Mizoram and for the next decade, he was in and out of various facilities, he would be clean for a couple of months and relapse again, and the cycle would repeat itself till he passed away a few years ago.

On the day he died, I woke up at around 6:00 AM since we usually open the shop early. I remember it was still very cold and I went straight to the kitchen to make myself some tea before opening the shop. As I walked past Robert's room, I could see that the door to his room was ajar. This was unusual since it was unlike him to be up so early, I figured he must've woken up at night and forgot to lock his door, so I reached for the door knob and tried to pull it close but then noticed his blanket was on the floor, I immediately opened his door and saw him lying there. He looked pale and cold and his eyes were closed. For a moment I asked myself what he was thinking lying on the floor on the cold January winter. I knelt down beside him to wake him up, I shook him on his shoulder but he was out cold. *He had already died but I could not bring myself to believe that so I told myself that it could be because of the cold air that his body had turned cold*. I called his name and continued to shake him as I pulled the blanket on his body but he did not respond. A little while later my brother and my parents came to see what was going on, my kids came running into the room as well. My brother checked for his pulse and told me that Robert was no longer with us. I couldn't cry, I did not believe that my son was not there anymore.

His funeral was held that same day at 1:00 PM and it happened all so fast. *The moment passed so suddenly that before I could even wrap my head around the death of my son, he was buried and his farewells were said. I had wished that if we could*

keep him for a little longer, he might have come back to life; he looked like he was in a deep sleep and as though he will wake up any moment. But the fact that he was no longer to join us in our family devotions, at dinner tables, his quiet rooms and the dark living rooms were a gentle reminder that my Robert was gone for good.

It is difficult to come into terms with his death, happening all so suddenly. Of course, as a mother, and *when your son is an addict, you do sometimes wish that in your desperate moments, you want things to change, that was what I used to feel*. When he was getting high with his friends or had some trouble with the law, I used to tell him in my angry fit that I wished he would be something else, or be somewhere else. *But when that moment hit me unexpected and so suddenly, I sometimes blame myself for wishing such thoughts on my own son. I would ask forgiveness to God and come into terms by praying for my son. I would ask God to forgive him for his bad habits. It sometimes makes me feel that the reason he turned out to be an addict was probably because I failed him as a mother*. Those thoughts would come into my head every now and then. But as any mother would, I want what was best for my son and when I seem to be at a loss, I would pray to God for my children. I am thankful to God for giving me a son like Robert, even if everyone else thinks otherwise, because it was because of him that I confide in God and seek his guidance. I used to think that if Robert was a different person, someone who was not an addict, I might not have been close to God as I was and still am today. It has been over five years since I found him lying on the floor that morning, and not a day has gone by without me praying for his soul to be forgiven for the ways he chose to live. Robert is a savior for me in a way that it is because of him that my faith in God is strengthened. *Although many would say that my overdose son was a no good person, someone who brought nothing but trouble to his family and as someone who was irresponsible, to me,* ***I feel that Robert has brought me closer to God.***

Many mothers are proud of their children being successful in their careers, earning money and names in their job and become successful, and I do not blame them. As mothers we all feel proud over our children. The society may not see my son as a "success" as it is defined, but in my opinion, he did the best he could and it was unfortunate of him that the temptations he fought were bigger than he could battle. Many mothers would feel that pride in sending their children off to become pastors and preachers, and it is indeed a celebrated thing, and for any missionaries and

preachers their ultimate goal is to preach the gospel in many ways to people and make them believe in God, my son did the same for me and even though he may not be a saint in many ways, my son's life and the prayers I have said on his behalf have made me a strong believer that God uses people and their lives in ways that we cannot explain, and there certainly are different measures that God uses in seeing who is fit and worthy. *I loved my son, and how he died may not be accepted by people in general, but I strongly believed that his choices of life and even in death have made me closer to God and that God will reward him for what he had done.*

4.1.3 Case Presentation of "The One That Loves" (see Appendix – H for Mizo Version):

The One That Loves

My ex-husband and friend of over thirty years passed away from drug overdose. I had no idea that he was using drugs again, but I was aware of his addiction issues. Before I married him, he had a terrible addiction to heroine, but overcame that and was sober for a couple of years before we started dating. He remained that way through our engagement and marriage until he had an injury and was prescribed pain medications. He became addicted to a few different ones over a few years. I talked to him about the effect it had on our relationship, and he sought counseling and actually got off them only to become addicted to another a short time later. I spoke to his counsellors and tried everything possible to help him get help. It didn't help that he was out of work because he had entirely too much time on his hands to use and have few responsibilities to keep him afloat, or at least a part of the family and part of society. We had two children in the midst of these years and I run my own business. He promised to care for the children while I worked, and I was very open to the idea of '*Mr. Mom'*, though he couldn't achieve success at that role because he often couldn't get out of bed. The lethargy and fogginess of taking so much pain medication made him irritable and constantly tired, and I believe even messed up his own ability to discern the real chronic pain he suffered from.

Finally, after a few years of living this way, and with a lack of motivation on his part to make a very big change as far as the drugs and his work life were concerned, I made the most difficult decision of my life: to ask for a separation. He was surprised and angry. He asked if there was anything he could do. I told him I'd

been talking to him for years about the same issues and I realized I couldn't make him change. I could though make a decision about my own life. And that was that I didn't want to spend the rest of our lives making him feel bad or being resentful of him. I loved him too much. So we cried and parted ways, and ventured into a horrible period of the divorce process, where people pit you against each other and there are all sorts of stress and stuff to contend with. Add to that his using turned from pain meds to street drugs, and it was a rollercoaster. He often didn't show up to see our children and they were just little ones. It was heartbreaking for me, and for them. We each became involved with other partners, and unfortunately, I later learned that his had suffered from a multiple addition when he came into the picture. I think it was like a tornado when they got together because both had issues to start with.

Well this all went on for years, but in between his bouts of anger with me, we were still friends. I always told him I'd help him and that I was really concerned about him. He denied everything until one day he confessed up and cried to me about his lifestyle, and I assured him I'd never use it against him, but wanted to help him get well. At this point, I remarried and my husband was even supportive of this plan. He got better for a while, but as all drug addicts' families know, it's a rollercoaster on again/off again thing.

I never lost hope for him, right up until his death. Very sadly, I lost one of my best friends in October last year. Then my ex-husband's girlfriend died. I was friendly with her also, and believe she was trying to reach out to me for help just a month before she passed. She OD'd also. After that, my ex's family stepped in (finally) and arranged an intervention. He went away, but he was grieving the loss of his. He came home and his family wrote him off. My husband and I and one of his friends helped him get through a few weeks of winter while we searched for a drug rehab program that he could go to as an inpatient.

All the while I kept his family posted on his well being, even though they wanted no part of him and made it very clear. I assumed, as a parent myself that his parents and siblings would sleep better at night knowing he was alive and fed with a roof over his head. Finally, I convinced them that he truly did want rehab and at the last minute, they stepped back in and joined us in getting him into another rehab out-of-state where he stayed for 45 days. I spoke to him routinely while he was there, and

we had some really good talks. Even though we'd been through so much in our relationship, we loved each other very much and were devoted to one another as the closest of friends. I never actually stopped loving him, which made all these decisions that much harder. Loving someone and having to end your marriage due to these issues is a very complicated and difficult place to be.

He came home and was well. It was so great to see him healthy and happy, and peaceful. But that was short lived. He had all kinds of challenges, from financial debt, to finding an apartment, to dealing with the loss of his girlfriend, and the judgments of many people. We were able to spend some good quality time with him, and for those weeks, I am forever grateful.

He was waiting to move into an apartment so his family finally agreed to let him stay with them for a week or two and that's where he died. The week before his death, I became concerned because I noticed some of his old addiction behaviours – not showing up on time to see the kids, etc. He avoided me when he was using because he knew I'd know. He avoided me for a few days during which, I later learned that he had a car accident and spent a night in the hospital with low blood pressure. He died a few days later on the couch in his family's home.

Fortunately, my kids and I and my husband were able to attend the services. They told us the doctor thought it was a heart attack or a blood clot. I'm sure they knew more than what they told me after hearing some stories about things that were going on that I was unaware of. The niceness was short lived, however. Suddenly, it was all about whatever death benefits he had – his family seems to think they were entitled to these above and beyond his kids. We had words about that and they have since made me the target of all of their anger about the whole situation. They have actually told me that I am the reason he turned to drugs. I offered to put a headstone at his grave (since the family was complaining about the costs for the funeral and there's no headstone there yet), and the reaction was hate-filled words of blame and anger and bitterness. These people don't even care about their son's children! I'm so hurt and we are all so grief-stricken still. I have compassion for them because I understand there's so much grief and mixed emotions, but there has been zero compassion for me or my children who really loved this man beyond belief.

I have no regrets about never giving up on him and I also don't feel angry at him for his relapse. I don't think it would be realistic to assume that one would be fully "cured" and recovered after only 45 days of rehab, and a few weeks back home, with all the reminders and temptations.

I'll never forget the goodness in this man – he was a wonderful human being who I spent many happy years with him and no matter what these people say, they can never take that away from me, or the love we shared. I miss him terribly and will never get past the pain of losing him. I can only hope that each day gets a little easier and that we will someday meet again.

4.1.4 Case presentation of "Father of One" (see Appendix – I for Mizo Version):

Father of One

I have been working under the government for almost two decades and happily married. We were blessed with a daughter two years after our marriage and she was our only child.

I had been posted in various places since my job demands it, however, with our daughter old enough to go to school, we decided for my wife and daughter to stay in our rented house in Aizawl while I was away. This was necessary because at times I would be posted in really remote areas where good schools are unavailable.

We had bought a place of our own in the city and settled here for over ten years, although I was posted outside the city, it was not that far off so I would stay at my post for the weekdays and come to the city during the weekends and holidays. After a couple of years of being posted outside the city, fortunately I was transferred to Aizawl.

I earned enough to give a comfortable life to my wife and daughter; we lived a reasonably good life with a house of our own, a secure income and a stable family. Although my wife and I have thought of having another child at first, my wife's health issues have not given us the opportunity to do so, nonetheless, we were happy with having one daughter that was caring, loving and brilliant in schools.

We had a very close relationship, we talked about almost everything, even when it was just the three of us sitting at the dining table, and we would laugh and

joke a lot. Lisa, our daughter, would say that she would not want to leave us even when she grows old because she was our only daughter and she would want to take care of us. Her mother and I would talk about her and what we want for her when she grows up. We had thought of everything, she was good in her academics so we would plan on where she would go for her higher studies. She was very good at math and she used to say she might become an engineer, and we would assure her that she can become anything she wants to be.

She grew up almost entirely with her mom, she did not socialise much as a child and would always stick to her mother or me even when we took her out to some dinner occasions with friends or families. My wife and I had decided that it was better for Lisa to finish her schooling in Aizawl and that we will only send her outside of the state for her colleges (if she wants to). That was the plan and even Lisa thought it was the best for her. As she grows older and into her teens, she had gone to a new school, studying in Class VIII, just started high school and was starting to feel like any teenager would. She no longer wanted me to drop her off or pick her up after school because she was embarrassed. Her mother and I would just laugh over it and felt proud and somewhat wistful that our little girl was growing up already.

Lisa was an active girl in the church, most of her friends from our community are from there as well, although she only had a handful to say the most. They were a close-knit group who would come over almost every weekend; they would watch movies, televisions and play around the house.

On her fifteenth birthday she asked her mother and me if she could have a mobile phone as a gift since most of her friends in school have one. Her mother and I gave it a little thought on that, and finally decided that she can have one, so she got what she wanted for her birthday. She was a responsible fifteen years old, studying in class – IX and had friends from school; we did not want her to feel left out among her peers. I had never denied anything Lisa asked me since she was a little girl. Her mother and I would even argue over it, my wife was more of a disciplinarian between the two of us with Lisa.

Christmas had always been our family holiday, we would invite friends and families over and we would visit as many as we can within the city. Our family has never spent Christmas apart and even Lisa knows this, so on Christmas that year, she

asked me if she can spend the New Year with her friends from school. She had told me that a few of them had planned on organizing a little get together to watch television, roast some chicken etc at a sleepover. She further said that she has always been with us during the Christmas every year and never complained, so it was only fair that we let her spend time with her friends in the New Year. I told her that her mother and I would discuss and will let her know, and as I discussed it with my wife, we both agreed that as she was big enough to do that, she may but only on the condition that she will come home the following day in time for the feast at the church in the evening. I still remember the smile on her face as we told her that, she seemed excited and told us that she will have her phone on the entire time and that we should not worry about her because she is a big girl.

On New Year's Eve, my wife and I dropped off Lisa to her friend's house and went to my parents' house for dinner. When we went back home and slept, the phone rang at midnight and it was Lisa calling us to wish us a Happy New Year. She was having fun with her friends and assured us that she will be home in time and that her friend's father would drop her off, it was like she knew that we missed her and the house was quiet without her.

The next day she came home in time for lunch, earlier than we had expected but a good surprise. Her mother told her to clean herself up and start getting ready after lunch since the feast was going to start at 3:00 PM. Lisa hurriedly went to her room then came back out, asking us if she could go out with her friends from the previous night after the feast. My wife and I figured that she was responsible enough, so there was no reason for us to say no to her this time too as long as she isn't home too late, so we told her she could go but will have to be home before 9:00 PM.

After the feast, we went home and Lisa was getting ready to go out with her friends, I offered to drop her but she said that her friends were on their way to pick her up. They had planned to go out to visit the Christmas lights decoration and assured us that she will not be home late. It was around 8:30 PM and Lisa had gone with her friends, we decided to wait up for her and by about 9:15 PM she hasn't come home yet. My wife called her phone and Lisa answered, she told her mother that they were on their way home but the traffic might take a while. About twenty minutes after the call she came home, she looked tired and was quiet unlike her usual self. We

asked her if she was alright and told us that she got carsick on her way home – she gets carsick so easily since she was a little girl, we didn't think it was something to be worried about. My wife then told Lisa that she should change her clothes and sleep in her bed and she'll feel better soon. Lisa then went to her room, and her mother made her a glass of lemonade which she thought might be of help, she told Lisa who was in the bathroom that she left it on her bedside table. A few minutes later, Lisa was in bed and we checked on her before we did the same too, she told us that she'll feel better in the morning and that we should not worry so much. She wished us good night and we all went to sleep at around 10:30 PM that night.

At around 6:30 AM my wife got out of bed and as usual she fixed tea for all of us. She would wake us up after that and we'd sit around for breakfast. At around 7:00 AM, I heard her opening Lisa's room to wake her up, since she was a light sleeper she never had trouble waking up in mornings. The next thing I heard was my wife screaming and wailing from our daughter's room, I rushed to Lisa's room which was next door to ours and saw her laying there, her mother holding her and shaking her, as if she was trying to wake her up. My heart sank and I quickly asked what happened. When I think back, it was like a bad dream, I vaguely remember that morning and anything that happened that day.

I held my wife and called Lisa's name but she did not respond. Death was the last thing on my mind even as I felt my daughter's cold hands in mine. We were both crying next to our daughter's bed, calling her and trying to wake her up but our efforts were useless. The neighbors had heard us and rushed to our house, we had not opened the main door so they kept knocking. I stood up, wiped my tears and walked towards the door. I had no idea what I was going to tell them because I did not know how or what had happened to my daughter.

As I opened the door, our neighbours rushed into hour house, asking us all kinds of questions – what had happened, how it happened, when it happened and anything they could ask, and the irony of the situation was that I was just as lost as they were.

As the community leaders and the church leaders came to our house, our friends and families had also arrived. By this time, they had laid Lisa on her bed and the house was cleared. They had called the police too since the cause of death was not

determined. The police officer called my wife and me to our balcony and asked us questions about what had happened.

We had done a life insurance for Lisa when she was a little girl, and my brother had called up the insurance representative and informed him of the death of our daughter. The insurance representative soon arrived on hearing the news, and with the police officer, we sat in our balcony to discuss about the necessary formalities. It was mandatory that we provide a medical examination report to the insurance company to claim the insurance, and apart from this, my brother thought that it might be a good idea to have the autopsy to help us get a closure on Lisa's death. What killed her will be something we will always ask ourselves if we don't have her examined, and the police officer also suggested that it was the best thing to do, so my wife and I signed the consent form to allow our daughter's body to be examined.

After the autopsy was completed, it was around 11:00 AM and it was the rule of the Young Mizo Association that any death that occurs before 9:00 AM should have a funeral at 1:00 PM the same day. However they were considerate enough to delay the timing of the funeral to 3:00 PM. We did not even know the cause of death since the autopsy reports were not issued yet, and the cause of death was given as *heart attack*.

Three days had passed after our daughter's funeral, and my brother had called me up in the morning to ask me if we want him to pick up the report at the hospital, my wife and I had not slept since Lisa was gone, she had been crying and exhausted, I hadn't been able to sleep as well, so he offered to help us out and he went to the hospital. He came to our house a couple of hours after that and told us that the office was understaffed due to the holidays and it took him a while to retrieve the report.

He sat us down at the dining table and gave us the envelope, I was scared of what I was about to know – what if my daughter had died due to some sickness that we might have neglected to have it taken care of, what if it was something we could've done, will I ever be able to forgive myself for what happened if that was the case, will Lisa ever forgive me for it, how would my wife feel. These were the questions I wanted answered but I was not sure if I was ready to know the truth.

As my brother opened the envelope, my wife took it from him and read it. I remember her sobbing and her hands trembling as she saw what was written, and she said *"This couldn't be"*. I immediately took the papers from her hand and saw what was written on it; right there in black and white it was written that **our daughter had died of an overdose**. In the details we learnt that Lisa had taken a combination of wine and cough syrup which caused a lethal combination.

What was more surprising to us was that we never knew Lisa was capable of doing such things. Learning the cause of her death was like a lie being told to us. We were confused, speechless and shocked.

My brother then said that the cause of death as written on the board on the day of Lisa's death was "heart attack", and the autopsy report says otherwise, and whatever happened has happened, therefore it was no longer necessary to justify ourselves. We agreed that Lisa's cause of death was not to be disclosed since it did not matter, and doing so will not change anything - it was better to let her go that way, without people judging her or drawing conclusions of their own without knowing anything. Till today we have decided that this remains within our family only.

When I look back on what my family has gone through, I do not regret my decision, and I do not feel any kind of remorse in not telling people that my daughter died of an overdose because she was not an addict. She was a sixteen year old girl that experimented on what everyone else was trying out, and that doesn't make her different from anyone else. She was unfortunate to be a victim and she deserves to go with dignity that she deserves.

I love my daughter dearly, and so does my wife. Till today we still wonder what could have been if we did things differently, but Lisa's death has tighten our bond more so than ever and with her gone, we strongly believe that she would want us to be happy.

Our Lisa may be gone, but our memories of her will continue to grow. We only had a few years with her when we could have plenty more but we know that she is now in a better place watching over us, and we don't want her to see us unhappy because of what happened. We miss her, and that is how we keep her alive.

We protected her in all the ways we could, and she turned out great, but for many parents, it is almost impossible to catch up with what goes on with these kids, and as much as we wish we could've done things differently, it was her time to go, and as her parents, it is our responsibility to let her go with the respect and love that she deserves.

4.1.5 Case presentation of "Brothers" (see Appendix – J for Mizo Version):

Brothers

I am the youngest of four children and I had one older brother. Both my parents are still alive and my two sisters are already married, and I now live with my parents.

While growing up my brother Andrew and I were inseparable. He was three years older to me - I tagged along with him everywhere and he never seemed to mind. A protective older brother and a role model, he was my hero ever since I was old enough to remember.

Andrew was the kind of person that everyone liked; he had friends from everywhere and was very generous. And overtime, his friends became my friends and we always hang out with the same group of friends. Talented and creative by nature, he used to love playing music, he mastered any musical instrument he laid his hands on, guitar, drums and keyboards were his forte and he was always willing to teach me. A patient brother and a forgiving friend, my brother liked the attention he got from many of his friends while growing up.

He was as good in making friends as he was in playing music, and that was what I admired most about him. I, on the other hand, was the quiet one. I was usually in one corner, quiet and shy, admiring my brother's brilliance. What was great about Andrew was that although I was always behind the scenes, he never made me feel like his shadow.

My parents felt that it was always better to be in the same school as him when we were growing up, and I was one to fully support their decision on this because I liked being around him.

Both my parents are devoted Christians, they hardly skip churches unless it was unavoidable and we were brought up that way. While my sisters had different stories growing up, Andrew and I were determined to write our own, and that we did.

We used to share a room and we talked about anything and everything. Often times we'd talk about music, our lives, what we want to be when we grow up and how our lives would turn out several years down the line.

He helped me with my home works while we were in school, taught me how to play the guitar and it is safe to say that everything I learnt about life…..and death, I learnt it from Andrew.

He was a bright student while in school, but he dislikes studying like any kid our age while growing up. When I was in middle school, he had just started high school and school was never his favorite place to be. I remember one day during lunch hour, he called me while I was in our class room and told me to get my bag; I did as I was told without even asking why. We climbed over the school fence from the back of the building along with a few other friends and that was my first time bunking class and it certainly wasn't our last. We went to the football field and watched a football match played by the local clubs and by the time we reached home at around dusk, our parents had received a call from the principal. We could see that my father was furious, as we quietly stood in the corner of our living room, we were warned that if anything of that sort ever happened again, we would be grounded, and as I looked over Andrew, I saw him grinning which seems to make my father more furious. I thought that my brother was brave and I admired his courage and if it wasn't for him, I most certainly would've cried.

Our parents were strict as any parents raising two teenage sons. When I was fourteen, Andrew was seventeen and by this time, we were both in high school. We formed a band with a couple of our friends and would spend weekends practicing in our room. While hanging around with other friends, it was common for people our age to start smoking, and it was the same for us too. By the time I turned fifteen, me and Andrew were regularly smoking and it was not big of a deal since everyone else was doing the same.

One weekend as we were gathering for our usual practice, one of our friends told us that another friend had given him a small amount of marijuana. We didn't see the harm in trying it out, there was a rush of excitement for each of us since it was our first time trying. We all smoked it that afternoon, and none of us were bothered by it. I remember Andrew telling our friend that he should get some more for the next practice, and within no time it has become a regular thing for us to smoke marijuana during our practice sessions. Although I cannot remember exactly how long it took us but our weekend band practices have become a pot smoking sessions instead, all in the safety of our room without our parents ever questioning us.

We had continued this for almost half a year when one day one of our friends came to the practice late. I remember it was a rainy day, and when the door opened, this friend was standing there, and he seemed happy and was alarmingly loud. He opened his backpack and took out a bottle of rum which he said he got it from a seller. We took the liberty of opening it and pouring a glass each for every one of us. That was the first time I drank alcohol and it was with my brother.

We were young teenage boys and it seems like a harmless thing to do at the time. No one stopped each other and even if we wanted to, we didn't want to be the coward who couldn't join in the 'fun' because of being scared of his parents. If we didn't join in, we weren't 'in', and we all told ourselves that it was a phase we'd grow out of once we grow older. Time passes and one drink grows into many more bottles, and by the end of the year, drinking too, became our regular ritual.

As school was going to end that year, like any other year we were to receive scholarship, and on the last day of school, we lined up in the principal's office with our allotment cards, waiting for our names to be called to collect our money. After a couple of hours of standing in line, it was our turn. A few minutes later, we had a certain amount of money handed to us, and at that point, me, my brother, along with our friends have already planned on celebrating the last day of school. We wanted to try something new, so we discussed among ourselves what it was going to be.

We went to our place to tell our parents that we were going for dinner at a friend's place and rushed out as soon as we changed. Our parents always thought that it was a good thing that Andrew and I shared a very strong bond, and never objects to us going out together since we always have each other's back.

When we arrived at our friend's place, they had told us that they got something to celebrate, and we eagerly asked what it was. That was when they pulled out a glass vile with a small amount of white powder inside it. I looked at Andrew and it seems as though he knew what it was, I confusedly asked him what it was and then he told me. It was a vile of heroin; on hearing that, I knew it was a hard drug, but nothing more. I had no idea how it works and what it could do, but I wanted to find out.

They said they were going to '*chase*' it, I didn't know what they meant, Andrew knew that I was more than terrified of needles and if whatever they just said involves needles, I was out. He then assured me that it did not, so my disappointments disappeared. We sat around a desk and they began setting it up. When we completed taking it, the high was so different than what I had felt from drinking alcohol or smoking marijuana, and it didn't take long for me to decide I wanted to do it again.

When we got home that night, Andrew and I talked about what happened, and before we know it, it was all we could talk about. It was obvious that we both wanted to try again, and that certainly was not our last time.

We continued buying it with whatever money we have saved, but it was expensive. Our parents never suspected a thing, so it was easier for us to make excuses to ask them money. We had only chased it for a couple of months but we were hooked. We learnt that by chasing we wasted a large amount, so Andrew told me that a friend of his injects himself, it works quicker and lasts longer. As afraid as I was of needles, Andrew told me that we don't need to worry about that because people uses insulin needles which are small and didn't even hurt.

He assured me that he had seen his friends do it and we can learn to do it too and I was convinced. The following day we went to his friend's house, who was willing to teach us how to use the needles, Andrew practiced it on himself and shot himself with the insulin needle for the first time, and to my surprise he got it right. I trusted him with my life, and I was more than willing to let him shoot me too, and that was our first time ever injecting ourselves, but it was not our last.

We continued this for almost a year till our parent began to suspect us. We were hardly home and it has been a long time since we practiced songs in our house.

It was apparent that most of our friends who used to come around before have become full blown addicts, and this let our parents to believe we did it too.

A couple of our friends were sent to rehab by their parents and a few others were either drunk or high on drugs. We were barely out of our teens and we didn't know any better. We weren't discreet and it was almost like we took pride in walking around the street while intoxicated.

My parents then learnt that we had reached the point where there was nothing to deny. We were dependent on our substances and there was nothing we could do. With endless nights of fighting and arguing around our house, Andrew and I stuck together and had each other's back. Even though things changed for everyone else in our family because of our substance abuse, it was the same for us, having each other's back.

A few months passed and our parents have made up our mind. Either they do something about us or things will become uncontrollable. We stole everything we could steal from around the house, sold them and use the money to buy whatever drugs we could find. Heroin was expensive, and since my addiction have surpasses my fear of needles, I didn't mind using other drugs that are cheaper, as long as they get me high. That was when our father decided that we are admitted to a treatment centre. However, they decided to send us to different centers because being together would only make things worse.

Andrew was admitted to a hospital facility while I was admitted to a faith based organization. I was in for almost a year while Andrew was treated for well over three months, and he visited me at the center once he got out. He looked well and seems to be recovering well, and that made me determined to be good too.

When my course of treatment was finally over and I got out, my brother and I still bonded and remain to be in good terms. We were both sober for almost two years until one day; we went to a wedding of a common friend.

That night we were out with few other old friends after dinner at the wedding, we sat and talked, catching up on our lives when out of nowhere we decided it was a good enough occasion to celebrate. We drank and one thing led to another, one of our friends had brought a vile of heroin and kept it at the table with syringes. Looking at

it, I remember how good it used to feel and it didn't take long for us to reach for the syringe.

Before we know it, we had started using again. There was no point in trying to hide from our parents. And once they knew, the fighting and the arguing started again. One evening at dinner, my father began telling us that what we had been doing is hurting the family. He mentioned that Andrew was irresponsible and it was his duty to look after me ever since we were children, and that he did not set a good enough example for me to follow. Andrew seemed hurt, yet he did not utter a single word. I then told my father that I did everything because I make my choices and it wasn't Andrew who made the decisions for me.

That night Andrew came to my room and we talked, he told me that it has always been good to be with me. He was in tears telling me that it was never what he wanted, to be a bad influence for me. I told him that nothing was his fault and that even people who never knew him became addicts and I becoming one was not his responsibility, for which he should never take the blame. I did not know what came over him that night but he told me that he should have taken better care of me as my older brother. We had never had a hearty talk like that, and if I had known that it was going to be our last, I wouldn't have told him to stop and just live in the moment. Little did I know that his 'moment' was to arrive the following morning.

My mother usually wakes up at around five in the morning to attend the prayer service at church. That morning, as usual, she woke up and her calling for my father was what woke me up. I could tell from her voice that she was in some kind of shock so jumped out of bed and rushed to where she was. My mother was sitting on the living room floor next to the sofa, and there I saw Andrew lying still. From the look on my mother's face I could tell something terrible has happened. It was about an hour later that I finally came to the understanding that my brother has died of an overdose. I was speechless; I did not know how to react or what I was supposed to do.

Admitting to the death of my brother has been one of the hardest things I have to experience. The following months were harder without him being around. Sometimes I would call his name without thinking then would realize that he was no longer there. Those are the moments when I feel this aching void inside me. And it was easier to bear when I don't think about it, and getting high allows my mind to be

pre-occupied. Another reason for my decision to keep using is that I want my parents to understand that my addiction is not my brother's fault. Even without him being gone, I still do what I want to do, and that night when Andrew took the blame for my addiction, it was because my parents made him feel that way, but I just want to prove my point to them that Andrew was not responsible. They can no longer blame him for what I choose to do, and yes, it does help me fell less alone.

If anyone should know, I believe it' me – My brother may have been an addict but he loved me like any older brother should love their younger brother, and his addiction was only a simple flaw he had, like every other human being because nobody is perfect.

4.2 Case Analysis

For the purpose of this study, five case studies have been conducted with respondents' age varying from 26 years to 52 years. An adapted version of The Texas Inventory of Grief – Revised (Faschingbauer, 1981) was used and the findings of the case study conducted may be further qualitatively presented in the following paragraphs.

The weeping widow mentioned that she found it difficult to get along with certain people after the death of Peter, especially Peter's father because of the relationship they had, which was mostly blamed to be the cause of Peter's addiction and his death. Losing interest in social activities was also part of the grieving process for her.

The praying mother said that it was mostly difficult for her in the morning. It reminded her of the time she found Robert dead on his floor; she mentioned that opening her shop in the morning was the routine she discontinued for a very long time.

The respondents admit that they felt anger and difficulty in sleeping, loss of appetite and cannot keep up with normal activities within the following three months of losing their loved ones.

Being upset and crying was the most common form of expressing their emotions.

The male respondents contributed that hiding tears was one of the ways they have responded to the painful memories while the female participants expressed that pre occupation with thoughts of the deceased brought back painful memories of the deceased.

For the first few months after the death of a family member each respondent reported they were in denial and difficulty in accepting the cause of death was mentioned by ‘father of one’

They all agreed to the fact that nothing will replace the deceased ad that loneliness will be part of their lives.

4.3 Focus Group Discussion

The focus group discussion was conducted with sixteen members of the bereaved families due to drug related death. There were nine female and seven male participants whose age fell between 19 years to 53 years old.

The first point of discussion to emerge, abandonment/rejection appears to corroborate accounts of the cohesion and uniqueness of the grief reaction due to drug related death (Barrett & Scott, 1990; McIntosh et al., 1992). One of the participants called drug related death the “ultimate personal rejection”.

The second point of discussion subsumed items indicative of a perceived loss of social support or ties and felt stigmatization following the death. A common feeling experienced by the participants is that *they feel stigmatized and simultaneously unsupported by members of their community because the death of their loved one is related to drug misuse*.

Aptly labeled by Barrett and Scott (1989) as the search for explanation, it was discussed that the bereaved individual requires acknowledging that a death has in fact occurred and understanding the reason(s) for the death.

The construct of guilt emerged as the fourth point in discussion. Guilt is perhaps the grief reaction most often mentioned in the wake of a drug related death. Rando (1993) stated that “in modest amounts, guilt characterizes most mourning experiences”. The participants substantiated this assertion on an intuitive level in that

losing a loved one to drug related death can be very easy to induce thoughts and feelings of guilt over acts of commission and/or omission.

The fifth issue in discussion taps into somatic reactions. Physical reactions are often a consequence of bereavement (Cowles & Rodgers, 1991; Lindemann, 1944; Parkes 1985). The participants describe the physical reactions such as disturbances in sleep patterns, fatigue, restlessness, nausea, pain & tension in the body, decreased immune system, and difficulty stopping activity, inactivity and unusual clumsiness.

The sixth discussion is interpreted as feeling oneself to be more or less responsible for the cause of the death. Most of the participants believed that they are in some way responsible for the death of another, this puts a unique burden on those who hold this view.

The seventh discussion appears to represent a self destructive orientation. The participants highlighted that this orientation often extends through at least the first twelve months after a death has occurred, and they stated that a recently bereaved individual is more likely to take less adequate care of him or herself.

The final discussion highlights to the feeling of shame and embarrassment. Lewis (1992) defined shame as “the feelings we have when we evaluate our actions, feelings, or behavior, and conclude that we have done wrong.” Evidence of embarrassment after the drug related death of a significant other was discussed by the participants that they had lied to others about the cause of death.

As is evident from this result, the death of a loved one or significant other is an event that invariably initiates the process of grief in those who were close to the deceased.

4.4 Key Informant Interviews

The purpose of the key informant interview was to have an understanding in the practices and rituals involving in time of deaths in the Mizo society. For the study, the key informants included were the local community based organization leaders and church leaders.

The community leaders gave information on the rituals and cultural practices involved in death were gathered. The church leaders gave the perspective of religious practices of Christianity on death and life after death was gathered.

The most active voluntary participants in times of death in the Mizo society is the Young Mizo Association, a grass root organization that was established to promote the ethics, cultural practices and rituals of the Mizo tribe. It may further be noted that they are the largest voluntary organization that branches out in every village, town and cities in Mizoram.

From the community leaders, it may be noted that there are various rituals and practices involved in dealing with death in the Mizo society which includes:

a) *Mithi in singsak:* a practice that involves the community volunteering in clearing the house of the deceased.
b) *Zualko:* this may be termed as a messenger to inform relatives and friends/the community of the death.
c) *Mithi lumen:* a condolence service wherein the members of the community would come together to support the family at the time of death and stayed up on the night before the funeral.
d) *Thlan laih:* this involves the people in the community voluntarily digging the grave on the day of the funeral.
e) *Mithi kuang:* the community also takes the responsibility of providing the coffins for the deceased.
f) *Mithi vui hunserh:* this practice is the main funeral service that involves the entire community to pay their respect for the deceased.
g) *Khawhar in riah:* on the night of the funeral, volunteer youth members would sleep over at the house of the family of the deceased to help them in their household chores and assist them in any other necessary activities around the house.
h) *Khawhar inleng:* the youth in the community would come over to have services to sing hymns and provide support to the families the following nights of the funeral.
i) *Mithi ral:* this is a practice wherein people would visit the families and pay them in cash or kind for condolences. This includes any person who would

like to pay their respect to the deceased and is not confined to the particular community but the entire tribe as a whole. It is usually given by members within the community and people who had known the deceased and their families.

From the point of the community leaders it can be said that the nature or cause of death, the family's position in the society as well as the deceased person's contribution and participation to the society while he was alive play an important role. Although the main aim of the Young Mizo Association includes promoting equality among the members of the community, they pay respect to those that had active participations and contributions in the society. The solidarity of any community is often measured on the strength of the Young Mizo Association Branch in the community.

In terms of the key informants from the church, Mizoram has been popularly known to be a Christian state, comprising of various denominations that follows different practices and follows different doctrines. Therefore, it can be said that the church's participation in funerals is crucial; however, different denominations commonly follow a similar pattern in terms of conducting funerals. In time of death, it is the responsibility of the church to conduct the funeral services, wherein the Pastor or Church Representative will conduct the last rites to the deceased at home where the funerals are usually conducted. This ceremony is then followed by another short service at the graveyard at the time of burial, where only a few members of the family and close friends would attend shortly after the funeral service at home. As far as the churches are concerned, it is their priority to maintain equality among members of the church who have passed away, irrespective of their cause of death or status of the family.

CHAPTER – 5

CONCLUSION

5. Conclusion

Each life is unique and different and so is each person's death

The research titled, "*Coping and social support in families bereaved due to drug related death in Aizawl, Mizoram*" is an attempt to study the process of bereavement. The purpose of this study was to look at the grief reactions to those who had lost their loved one due to drug related death. It is a study conducted to understand the lived experiences of the bereaved families and to explore the available support systems for them. Information has been sought through qualitative means, from bereaved families using case studies and focus group discussion as well as key informant interview.

Mizoram is a state where drug misuse is considered as one of the major social problems with 1241drug related death reported since the first case reported in 1984 till June 2013 (Mizoram Excise and Narcotic Department).

The study is the first of its kind to research the grieving pattern of drug related death.

The objective of the study were to profile the characteristics of drug-related deaths that has occurred in Aizawl and understand the lived experiences of grief and bereavement in relation to drug- related deaths to identify the coping mechanisms used by the family member and to study the availability of the support systems for families bereaved due to such deaths.

The study is exploratory in design and cross- sectional in nature. Qualitative methods were used to collect data on the grieving pattern, nature of drug related death, coping mechanisms and social support available for them.

Multi-stage sampling was used. In the first stage, Aizawl was purposively selected due to the fact that it records the highest records HIV/AIDS (MSACS) related deaths in Mizoram. In the next stage, three urban localities with highest drug related deaths in the stipulated timeframe were selected from the Mizoram Excise and Narcotic Department [Drug Related death (Year-wise) w.e.f 1984].

In the third stage of sampling, a final sample was selected using proportionate sampling to keep gender and the localities represented. The family members of the

identified families were contacted. Consent was sought for the study after the purpose of the study was explained and one or more family member each (spouse/parent/sibling or adult son or daughter of deceased member) were interviewed based on their voluntary participation. In all, a total of 20 in-depth interviews were conducted for the five case studies that are presented. In addition key informant interviews were conducted with (designations) to augment the data and understand the nature of reality surrounding drug related deaths in Mizoram.

The following tools were used in the study:

a) Case study was conducted using an adapted version of Texas Revised Inventory of Grief (TRIG). **(**Faschingbauer, 1981) guide which was constructed to develop a profile of drug-related deaths, document family particulars, nature of death, and history of bereavement, coping and social support.
b) Key Informant Interview guide was constructed to collect information on bereavement and rituals associated with death from church elders, community leaders and govt. functionaries and NGO personnel. The data collected from such interviews help understand service providers and community perceptions related to drug deaths caused by use of drugs.
c) The focus group discussion guide was prepared with the help of The Grief Experience Questionnaire (GEQ: T.W. Barrett & T.B. Scott, 1989). The GEQ is a multi dimensional scale tapping into various dimensions of grief. It assesses grief reactions that are potentially problematic after any mode of death.

The discussion was framed within the context of eight factors containing fifty five sub topics that indicates abandonment/rejection, stigmatization, search for explanation, guilt, somatic reaction, responsibility, self-destructive orientation and shame/embarrassment.

The discussion was held with a purposively drawn sample of parents, siblings and spouses representing bereaved families in drug-related deaths.

In conclusion the following have been observed.

Physical Symptoms of Grief: Disturbances in sleep patterns, fatigue, restlessness, nausea, pain & tension in the body, decreased immune system, difficulty stopping activity inactivity, unusual clumsiness.

Emotional Symptoms of Grief: Crying, sadness, fear & anxiety, numbness and/or emptiness, loneliness, anger, helplessness, irritability, a sense of observing yourself, guilt, reduced confidence, lowered self esteem, loss of interest in previously enjoyed activities.

Cognitive Manifestations of Grief: Slowed thinking or processing, difficulty making decisions, mental confusion, daydreams or flashbacks, talking to the deceased loved one.

Spiritual Manifestations of Grief: A sense of closeness to God, a sense of distance from God, anger at God, isolation from one's spiritual community, sensing the deceased loved one's presence.

Social Manifestations of Grief: Isolation/withdrawal, preoccupation with one's own feelings and needs to the exclusion of others, marital or relationship stress, loss of interest in sex, impatience with others who are also grieving the same loss due to different grieving styles.

The respondents reported a number of related losses (often unanticipated) after the death of a close family member (e.g., spouse), such as the loss of income, lifestyle, and daily routine - all important aspects of social support.

Gender:

In general, men experience more negative consequences than women do after losing a loved one. This research might suggest that the mechanism for this difference is the lower level of social support provided to bereaved men than that provided to bereaved women.

Age:

Younger bereaved persons experience more difficulties after a loss than do older bereaved persons. These difficulties include more severe health consequences,

grief symptoms, and psychological and physical symptoms (Stroebe W, Schut H). The reason for this age-related difference may be the fact that younger bereaved persons are more likely to have experienced unexpected and sudden loss. However, it is also thought that younger bereaved persons may experience more difficulties during the initial period after the loss but may recover more quickly because they have more access to various types of resources (e.g., social support) than do older bereaved persons.

Personality Characteristics:

Attachment theory (Bowlby, J) has suggested that the nature of one's earliest attachments predicts how one would react to loss. Bereaved persons with secure attachment styles would are least likely to experience complicated grief, while those with either insecure styles or anxious-ambivalent styles are most likely to experience negative outcomes.

Coping:

Coping with death is usually not an easy process and cannot be dealt with in a cookbook fashion. The way in which a person will grieve depends on the personality of the grieving individual and his or her relationship with the person who died. The death experience; one's cultural and religious beliefs, coping skills, and psychiatric history; the availability of support systems; and one's socioeconomic status all affect how a person will cope with the loss of a loved one.

Attachment theory posits that humans strive from emotional bonds with others to feel safe and secure (Bowlby, 1969). Similarly the participants described how they had felt emotionally connected with the deceased. The theory of Continuing Bonds explains connections with the deceased can continue even after death (Steffen&Coyle, 2008). This is often described as a nearness or closeness to the loved one who has died. Other research suggests that his continued relationship can also be frightening to the living individual experiencing it (Steffen & Coyle, 2008). The company, the comfort and the security they have felt with the loved one was mentioned as a reminder of them. It is clear to many of the individuals that the deceased still had much significant control over their emotions, thoughts, and behaviors even after they are gone.

Sudden Death:

Drug related death is often sudden death that brings particular feelings and issues. Shock and disbelief are caused by the unexpected and devastating nature of the experience. While one can never feel completely prepared for a death, a sudden death leaves a person feeling particularly vulnerable.

It is not possible to address the many issues exclusive to drug-related death. However, there are some similar issues and specific feelings that the respondents commonly confront.

The most overwhelming and common reaction to a drug related death is shock and uncertainty. This result in feeling disconnected to their feelings or to other people; which is interpreted by the respondents as if they are living in a dream.

The initial news and stages of grief of the respondents could be characterized as disbelief, accompanied by feelings of numbness or a belief that the deceased is still present.

The unexpected nature of the death had left them with an “absent grief”, as if the event has not occurred or the significance has not registered or yet been acknowledged. Not only they are subject to the usual grief feelings, but they had been deprived of the opportunity to prepare for the death. They reported that they were not able to gradually understand, cope or adjust to the possibility of the death or say their goodbyes in a personally satisfying way.

The common feelings expressed by the respondents are feelings of unfinished business and missed opportunities, and regrets for things not done or said to the person who has died. The families have encountered tremendous feelings of guilt, believing and wishing there was something they could have done to prevent the death. It is a common feeling expressed to blame themselves or to search for answers and meaning by seeking the cause of death in something or someone.

Strong feelings of helplessness had been manifested in displays of anger, agitation or immobilization.

Because of the sudden nature of the death, an unexpected sequence of feelings had been experienced. A delayed grief reaction resulting from the difficulty of being able to initially comprehend the events or meaning of the death had been experienced.

Social support:

Social support is a highly complex construct, consisting of a variety of components and measured in a variety of ways. However, lack of social support is a risk factor for negative bereavement outcomes: It is both a general risk factor for negative health outcomes and a bereavement-specific risk factor for negative outcomes after loss (Stroebe W, Schut H).

Religious Beliefs:

Theory has proposed that strong religious beliefs and participation in religious activities could provide a buffer to the distress of loss:

- A belief system that helps one copes with death.
- A network of social support that comes with religious participation.

However, the results about the benefits of religion in coping with death tend to be mixed, some showing positive benefit and others showing no benefit. The study showed that a positive benefit of religion tend to measure religious participation as regular church attendance and find that the benefit of participation tends to be associated with an increased level of social support. Thus it appears that religious participation such as regular church attendance and the resulting increase in social support may be the mechanisms by which religion is associated with positive grief outcomes.

Bereavement has been defined as the objective situation one faces after having lost an important person through death (Stroebe MS, Hansson RO, Schut H, et al., eds.). It is conceptualized as the broadest of the three terms (Bereavement, Grief and Mourning) and a statement of the objective reality of a situation of loss through death-logic, or complicated.

Elizabeth Kubler Ross' Five Stage of Grief (2005) was adopted for representing the data collected. Kubler-Ross originally developed this model based on her observations of people suffering from terminal illness. She later expanded her

theory to apply to any form of catastrophic personal loss, such as the death of a loved one, the loss of a job or income, major rejection, the end of a relationship or divorce, drug addiction, incarceration, the onset of a disease or chronic illness, an infertility diagnosis, as well as many tragedies and disasters (and even minor losses).

Supporting her theory, many (both sufferers and therapists) have reported the usefulness of the Kubler-Ross Model in a wide variety of situations where people were experiencing a significant loss. The application of the theory is intended to help the sufferer to fully resolve each stage, then help them transition to the next – at the appropriate time – rather than getting stuck in a particular phase or continually bouncing around from one unresolved phase to another.

The stages, popularly known by the acronym **DABDA**, is applied to identify the themes:

Denial: Denial can be conscious or unconscious refusal to accept facts, information, or the reality of the situation.

Denial is a defense mechanism and some respondents could be identified as being locked in this stage."I feel fine."; "This can't be happening, not to me" are the words they had used which are associated with denial. For most of the respondents denial seemed like a temporary defense for the individual for a short time. These feelings of denial experienced by them were generally replaced with heightened awareness of possessions and individuals that will be left behind after death.

Anger: Anger had been manifested with the respondents in different ways. They have expressed being angry with themselves, or with others, and especially those who are close to them and who they feel were responsible for their addiction.

"Why me/him/her? It's not fair!"; "How can this happen to me/him/her?"; '"Who is to blame?" were the expressions associated with anger.

Because of anger, the person is very difficult to care for due to misplaced feelings of rage and envy was mentioned in the FGD by members of the same family.

Bargaining: It is the hope that the individual can somehow postpone or delay death. "I'll do anything for a few more years."; "I will be loving if only" were the expressions used by the respondents. Usually, the negotiation for an extended life is

made with God in exchange for a reformed life. People facing less serious trauma can bargain or seek to negotiate a compromise. For example "Can we still be friends?..". Bargaining rarely provides a sustainable solution, in the matter of life or death was the conclusion made.

Depression: Depression could be referred to as a kind of acceptance with emotional attachment. The expressions used by the respondents associated with depression were "I'm so sad, why bother with anything?"; "I miss my loved one, why go on?" The respondents expressed becoming silent, refuse visitors and spend much of the time crying and grieving. It was mentioned that they felt free in disconnection from things of love and affection. The respondents considered that it is natural to feel sadness, regret, fear, and uncertainty when going through this bereavement.

Acceptance: The respondents expressed their acceptance with words such as "It's going to be okay."; "It has happened. I might as well move on"... It could be referred to as coming into terms with mortality, or that of a loved one, or the tragic event. Acceptance varies according to the person's situation. Some of the respondents losing their loved one confirmed that as early as they acknowledged the death, for some it happened shortly after the death and for some respondents' acceptance is still very difficult till date.

The study has identified the grieving pattern of the families that have lost a loved one due to drug related death and the coping mechanisms were identified. This helps in the conclusion that turning to God and the church was the main coping strategy adopted. Religion and spirituality place an important in consolidating with bereavement.

The available social support systems were also learnt and from the study it can be seen that Mizo society grief as a community which has its advantages as well as its disadvantage. Grieving in groups have helped the bereaved family to feel not alone and finding social belongingness and solidarity as a society. However this made it difficult to find closure in grieving as an individual.

It was also learnt that there are pattern of 'social exclusion' involved in the bereavement process when the causes of death are unnatural. This social exclusion comes from the bereaved families even though it is a social norm that everyone is

treated with equality, the bereaved families felt that the nature of death does justify to the social support systems that are available in the society. Society also played their role in social exclusion by their perception and attitude towards drug addicts and drug related deaths.

This study on drug-related deaths has been a very new area of research and it documents the lived experiences of persons who are bereaved. Interestingly all the case studies preponderantly discuss the issue of loss of a very dearly loved member and the struggles associated with a past that was full of bitter frustrations. Despite having left the marriage, in some cases a bereaved member poignantly recalls the love and positive strengths of a relationship that went awry.

In conclusion, it does appear that most families look towards each other for strength and support. Secondary and tertiary support even when available is not adequate. A dominant theme that emerges is also the relationship with God being a coping strategy. It seems to offer a perspective besides reinforcing positive energy and offering solace and comfort. The Focus groups also reveal that members who have had a drug abuser in their families experience stigma and discrimination in the community. From the point of the community leaders however, key informants state that factors such as the nature or cause of death, the family's position in the society as well as the deceased person's contribution and participation to the society while he was alive play an important role. Therefore this undermines the drug abuse *per se* leading to stigma and discrimination.

Summarily, the study offers some suggestions within a social work perspective based on the understandings gleaned from the case narratives, focus groups and interviews with Key informants.

1. Social Support groups would go a long way in helping families in the bereavement. Self help initiatives of this nature may be initiated by social work professionals or facilitated by them. Such groups would provide a platform for discussion, help in catharsis but also help people deal with issues of guilt, shame and stigma that arise in the aftermath of a drug-related death.

2. Strengthening secondary and tertiary sectors for care-givers to allay burdens faced in dealing with drug abusing members for families is indicated. While a

member is alive itself, primary caregivers require a lot of help. This would involve networking with Non Governmental Organizations, Community Network Organizations, and Faith Based Organizations etc. Church elders and faith based organizations in particular may offer best support in the absence of primary social support.

3. Research on various aspects of death, dying and survival and coping is required. This study was an exploratory one but what is required is a lot of research that documents the very positive life stories of people who have a drug-using member or those who lost a member to drugs.

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APPENDIX – A

SUMMARY OF PILOT STUDY

As per the requirement of the course, fieldwork for first semester of M.Phil was from the 28th October 2013 to 16th November 2013. A total of 17 days fieldwork was put in and objectives were laid down in order to have a more systematic and thorough study on the topic.

The topic for the fieldwork is "Exploring the grief pattern of families bereaved due drug overdose".

As the topic suggests, it is important to understand the concept of grief bereavement and how it is defined.

When a person loses someone important to them, they go through a normal process called *grieving*. Grieving is natural and should be expected. Over time, it can help the person accept and understand their loss.

Bereavement is what a person goes through when someone close to them dies. It's the state of having suffered a loss.

Mourning is the outward expression of loss and grief. Mourning includes rituals and other actions that are specific to each person's culture, personality, and religion. Bereavement and mourning are both part of the grieving process.

Grieving involves many different emotions, actions, and expressions, all of which help the person come to terms with the loss of a loved one.

OBJECTIVES:

The **objectives** of the fieldwork are:-

e) To understand the concept of grief and bereavement.
f) To find out the causes and consequences of overdosed deaths.
g) To identify and study the impact of over dose deaths to the families.
h) To study the availability of the support systems for families bereaved.

These objectives were drawn in order to gain knowledge and understanding and gather information to help and add validated data with regards to the topic.

METHODOLOGY

The methodology employed in the fieldwork on "exploring the grief pattern of families bereaved due to drug overdose" includes: case study, participatory rural appraisal, focused group discussion and interview in order to understand the situation of bereaved families. Case study method was used to gather information on the grieving pattern of the bereaved.

The methodology used to gather the required information is:-

a) Case Study: Case study was conducted with a bereaved mother who is 61 years of age. Who lost her son due to drug overdose in 2005. From this case study it was learnt that there are multiple grief symptoms that briefed individual experienced.

b) Participatory Rural Appraisal (PRA) is people's involvement in a process of learning about the conditions in an intensive, alternative manner. It characteristically relies on small multidisciplinary terms that employ a range of methods, tools and technique specifically selected to enhance understanding condition, with emphasis on tapping the knowledge of local inhabitants and combining that knowledge with modern scientific expert.

The research scholar has conducted cause and effect PRA among 17 Young Mizo Association (YMA) members whose age group was between 19yrs – 40 yrs. The gender of the participants is not specific in nature.

The outcome of the cause and effect diagram may be highlighted as follows:

Cause and Effect of Overdose Deaths:

Cause	***Effect***
Addiction	*Shock/Trauma*
Intravenous Drug Use	*Social Stigma*
Unavailability of quick medical response	*Anger, helplessness, guilt and shame in the families*
Mixing of different kinds of substances (drugs and alcohol)	*Depression*
Ignorance of adverse affects of narcotic drugs	*Anxiety*

c) Focus Group Discussion: *Focus Group Discussion (FGD)* focused on particular group of people which is administered to fulfil the fieldwork objectives.

The research scholar conducted two focused group discussion among different groups – families (grieving within the family) and youth (perception of overdosed deaths)

In the discussion with the families, it was observed that death by overdose is loaded with social/moral stigmas, in addition to strong feelings of anger, helplessness, guilt and shame in the families. The objective of this study was to analyze the impact of these feelings on families facing death by overdose. Qualitative methodology was used to study families with a history of death by overdose of one of their members. The interview was open, and guided by the question *"What did you feel with the death of your family member by overdose and what was the impact of this death on your family as a whole?"* The families were grouped into two categories: families who knew about the drug use of their family member, and families who were not aware of it. The reports show that secrecy regarding drug use followed by death by overdose arouses feelings of anger, guilt, helplessness, and deprives the family members of information that could allow them to take action. As regards to families that were aware of the drug use, there seems to be a "veiled preparation" for a possible death by overdose, bringing about ambivalent situations of grief and relief. The report stresses how disturbing it is to lose a family member by overdose, and points to the need for psychological support for those families.

The youth were given a topic on their “perception of overdosed deaths”. The responses were mixed the participants feel differently about the situation. While some considered that overdosed death are no different than any other accidental death that happens suddenly and feel non-judgemental about the deceased, some feel that it reflects the morality of the individual and that their addiction are often caused by loose upbringing and behavioural problems. It was however, a common consensus that the reaction of the community is more on the individual rather than the cause of death. Since Mizo society is a very close knitted society, people tend to have more sensitivity to those that are involved in the community than those that doesn’t. While many substance abusers isolate themselves from the society, there are some that are actively participating in community works. It was mentioned by the participants that not all substance abusers are a menace to society, and when these active members of the society who are substance abusers die due to drug overdose (in very few cases), they are treated no differently than people who die with other causes. On the other

hand, when a substance abuser who isn't involved in community activities die, people don't necessarily stigmatize them, but the lack of their social interaction often lead to a lesser turn up in times of community condolences. The youth agrees that it is more of a person's behaviour that determines his status in the society rather than the cause of his/her death.

d) Interview: The interviews conducted were mostly informal. The community leaders, church elders and personnel from Excise and Narcotic Department were interviewed to gather necessary information and data.

Personnel from Excise and Narcotic Department: the research scholar approached an officer from the department to inquire about the drugs commonly misused in Mizoram. The interviewee mentioned that the department have faced a new challenge in fighting the illicit drug trade. A decade ago, the main kinds of narcotic drugs used among the substance abusers come from the neighbouring states like Assam and Manipur. However, there has been a changing trend where drug smuggling is on the rise from the international border of Myanmar. This new drug route used by smugglers is difficult for the government to deal with since it has international ties and cannot be undertaken by the state alone. He also added that the geographical setting of Mizoram makes it an easy hub for smuggling due to its international borders from two sides – Bangladesh and Myanmar.

Community leaders and church elders: The purpose of this interview was to get the response of the community leaders and church leaders with regard to members of their community facing overdose death. The research scholar was interested in finding out whether the community treats the bereaved families of differently or if there are any different perceptions on death caused by drug overdose. This includes the funeral processions and the community's traditional ways of dealing with death.

The community leaders responded by saying that as an organization, it is their priority and sole duty to treat each and every member of the community equally, they try their best to maintain that moral.

However, they often fear that the community may not turn out well in the traditional practice of "community mourning" processes. They mentioned that they encouraged the youth in the community to participate in such unfortunate occasions as

much as possible for social solidarity, in order to further encourage this, they have now stopped announcing the cause of death on public announcement systems when there is death within the community to maintain equality, irrespective of the causes of death.

The church elders were also interviewed and asked their roles and participations of the church when there is death in the community due to drug overdose. According to the Christian belief, death due to substance abuse can be a reflection of the morals and personal life choices made by the individual. They are often regarded as against the beliefs of the church teachings and the church elders often find it hard to justify these deaths. Nonetheless, as Christians, they are taught to be compassionate and impartial towards such instances. They see it as an opportunity to preach the gospel and set an example for others. They admit that as believers, they are not to judge these individuals, but at times they feel that the society shows some kind of stigmatization to people who die due to drug overdose, mainly because substance abuse in itself is a socially unacceptable behaviour, and also because it contradicts the religious beliefs of the people. But as a church, they fulfil their duty to God and as society dictates, by giving them a respectable funeral services similar to those having a natural cause of death or any other cause for that matter.

Registrar of Birth and Death: The research scholar interviewed the registrar of birth and death in the community to gather data on the number of deaths within the year of 2013 due to drug overdose. From the recorded data, it was seen that there was a total of 13 deaths within the year of 2013 due to drug overdose. Of which 3 are female and 10 are male, their age varies between 16 years and 31 years. An interesting remark made by the registrar was that there were times in the Mizo society when overdose death were recorded as heart attack or other natural causes as requested by the bereaved families due to the fear of judgement or stigmatization from the community. This was so because it was considered as a disgrace and humiliation by the family to lose their loved ones due to drug overdose. This trend is slowly disappearing and people tend to be more forthcoming with cause of death in the society today.

WORK DONE

Visit to Palliative Care Unit: Apart from the work done mentioned in the methodology, the research scholar also visited the Palliative Care Unit at Mizoram State Cancer Institute, Zemabawk. The main purpose of the visit was to interact with the Medical Officer and ask her about the palliative care unit at the Cancer Hospital. The interaction resulted in the Doctor in charge explaining the purpose of the unit and how it aims to help people suffering from terminal illness to deal with their health issues.

Mostly, the severities of the cases they have at the hospital are not similar, some patients after they are diagnosed, are given a few months to live while others may be given years. Patients often feel depressed, confused, stressed and hopeless after being diagnosed with cancer; this affects not only the patients but their families as well. The palliative care unit provides counselling and support for the patients and help them maintain a positive attitude during the course of their treatment. The medical officer further adds that these counselling greatly help the patient's mental wellbeing and fighting terminal illness requires not only a positive and mentally strong patient but their families as well.

Meeting with Psychiatrist: The research scholar interacted with a psychiatrist to seek professional opinion and insight on the grief and bereavement concept and its practice in the Mizo society. From the interaction, it was noted that the Mizo customs and practices are very different from that of other societies. The community condolence practice where the community comes together and consoles the grieving family by keeping them company and singing is not seen in other communities. This practice has been done since time immemorial and it is a very distinct identity shared by the Mizo tribe.

However, with the advancement of time, people feel less obligated to be socially participative; privacy and independence are slowly gaining momentum and our ways of dealing with grief is also gradually changing. In a social environment where one's obligation to society is more important than one's own need, even when we lose someone close to us, we have to follow what is acceptable, thereby neglecting our own need to grief, mourn and get closure in order to live a psychologically healthy life. Many people who lost their loved ones often don't have time to grief,

their duty to the society comes first and this leads to unresolved feelings, which could lead to severe mental health issues.

The psychiatrist mentioned that in the older generation, people feel that seeking professional help especially for grieve are a rare occurrence. Seeing a mental health professional was regarded as something that should only be done by people having severe mental and psychiatric issues. But as people become more aware of the importance of mental health in the society, the trend is slowly changing as well. Especially on the grounds of grieving, people who lost their siblings or spouses due to drug overdose, like any other accidental death, are traumatic and sudden. This could lead to serious mental health issues like depression, abandonment, isolation, behavioural disorders etc. and if they don't find a healthier way of dealing with their loss, it could affect their lives adversely.

Appendix - B

Grief responses to Drug Related Death

What is the research about?

Research has shown that those who have lost a family member due to drug related death may experience several feelings of grief. The purpose of this study is to study better understand the loss process.

How will we study this?

We will be interviewing volunteers about their history with the deceased person and the physical, emotional and relationship reactions they have experienced since the loss.

Who may participate?

Anyone in the community, that have lost a loved one due to drug related death in the year between 2007- 2013 (June).

When will it be and how long will it take?

The interviews will be conducted between March - September 2013, anytime you are available will be appreciated. The interview will last about thirty minutes or more. Three or more meetings might be needed.

Who is conducting this research?

Esther Lalrinhlui Ralte, M.Phil Research scholar, Department of Social Work, Mizoram University will be conducting the research. She can be reached at 0389-2343812

How do I get involved?

Read and sign the informed consent and then give it to the community leader(s) who gave you this flyer or contact me and I will personally collect them.

Consent to participate in a Research Study

Study Title: Coping and social support in families bereaved due to drug related death.

Research Scholar
Esther Lalrinhlui Ralte
M. Phil Scholar
Department of Social Work
Mizoram University

Research Supervisor
Dr. Kalpana Sarathy
Associate Professor
Department of Social Work
Mizoram University

Sir/Madam,

I, Esther Lalrinhlui Ralte, M.Phil Scholar, Department of Social Work, Mizoram University, am conducting a research on *"Coping and social support in families bereaved due to drug related death"* in order to have an understanding of the lived experiences of the individual or family members that have lost a loved one due to any kind of drug related death.

The study will be confidential and will not reveal your identity. The study/interview reports will be presented in my dissertation. There will be no financial benefits provided to you for this study.

If you consent to participate in this study please give your signature below.

_____ (Signature)

Thank you.

**if consented, please provide contact information (phone number)*

Appendix B

(Mizo Version)

Ruihhlo avanga chhungte sun tawh zirchianna

Eng zir chianna maw?

Zirchianna (research) thenkhat chuan ruihhlo avanga chhungte sun tawh hian thil tam tak an paltlang niin a sawia. Chu'ng thil hrang hrang te zirchian chu he research in a tum ber ani.

Eng tia zirchian tur nge ?

Ruihhlo vanga boral tawh chhungten an mahni duh thlanna ngeiin he zirna ah hian an tel theia. Mimal inkawmna (interview) hmangin an hmangaih kalta nena an laichindan leh inkungkaihna te zir anih bakah an boral hnua rilru,taksa leh inlaichinna kawnga an thiltawn/ nghawng dan (experience) zir ani bawk ang.

Tute nge tel thei ?

In veng chhung ami kum 2007 – 2013 June inkara ruihhlo vanga thi chhungte tupawh a tel theih.

Engtik ah nge? Eng hunah nge?

Interview hi March - September 2013 a tel turte remchan hun ah neih ani ang. Interview hi darkar chanve (aia tlemlo) in vawi thum emaw aia tam neih ani ang.

Tu in nge rawn zir chiang dawn?

Esther Lalrinhlui Ralte, M.Phil Research scholar, Department of Social Work, Mizoram University ka ni a. Phone number 0389-2343812 ah biak pawh theih ka ni e.

Engtin nge ka tel ve theih ang?

Rem tih na lehkha (consent form) rawn thil tel a ni a, uluk takin chhiar la, hming signna tur awl ah sign in, he lehkha pe tu che (vengchhung hruaitu te hnenah) pe leh in emaw, phone number ka dah ah khian min han hrilh la ka rawn lam dawn nia.

(Mizo Version)

Zirchianna (Research) a tel remtih na

Study Title: Coping and social support in families bereaved due to drug related death.

Research Scholar
Esther Lalrinhlui Ralte
M. Phil Scholar
Department of Social Work
Mizoram University

Research Supervisor
Dr. Kalpana Sarathy
Associate Professor
Department of Social Work
Mizoram University

Ka pu/pi,

Kei, Esther Lalrinhlui Ralte, MPhil Scholar, Department of Social Work, Mizoram University hian *"Coping and social support in families bereaved due to drug related death"* tih thupui hmangin zirchianna ka nei meka, ruihhlo vanga chhungte sun tawhten an tawrh dan, enge an paltlang tih leh khawtlangin an tawrhpui emaw an tanpui dan te zir ani ang.

I nihna, (hming leh veng etc.) te thup ani anga, hemi hun chhung a kan record leh hmuhchhuah te chu ka research report(dissertation) ah ziah ani ang. He research ah hian sum leh pai hamthatna erawh in pek ani lovang.

Hengte hi i pawma, i phalna ngei a he zirchianna a tel ini tih lantir nan a hnuaia awl ah khuan i hming i sign dawn nia.

_____ (Signature)

Ka lawm e.

**i rem tih a, he research a i tel thei anih chuan i phone number ilo ziak tel dawn nia.*

APPENDIX - C

Case Study Guide

PART - I: PAST EXPERIENCES

Think back to the time when you lose the person/family member, and answer these items about your feelings and actions at that time.

1. After losing him/her, do you found it hard to get along with certain people?
2. Do you found it hard to work well after losing him/her?
3. After losing him/her, do you lost interest in your family, friends, and outside activities.
4. Were you unusually irritable after losing him/her?
5. Were you able to keep up with your normal activities for the first 3 months since losing him/her?
6. Were you angry with having to lose the person you love?
7. Do you found it hard to sleep after losing him/her?

PART – II: PRESENT EXPERIENCES

Now answer all of the following items by checking how you presently feel about the loss of him/her.

1. Do you still cry when I think about losing him/her?
2. Do you still get upset when you think about him/her?
3. Do you have difficulty in accepting the loss of him/her?
4. Do you sometimes very much miss him/her?
5. Is it still painful for you to recall memories of him/her?
6. Are you preoccupied with thoughts (often think) about him/her?
7. Do you hide your tears when you think about him/her?
8. Will there be anything or someone to ever take the place in your life of him/her.
9. Can you avoid thinking about him/her?
10. Do you feel it's unfair that you had to lose him/her?
11. Do things and people around you still remind you of him/her?
12. Are you able or unable to accept the loss of him/her?
13. At times do you still feel the need to cry for the loss of him/her?

APPENDIX – C

(Mizo Version)

Case Study Guide

PART - I: HUN KAL TAWH

Ruihhlo vanga (I chhungte/laina a) boral lai kha ngaihtuah chungin heng zawhna te hi i chhang anga, khang hun laia i rilru put dan leh ngaihdan te kha i sawi dawn nia.

1. A boral tirh khan rualpawl/kawm harsa i ti em? or Kawm harsa tih bik i nei em ?
2. I lusun tirh khan i hna chhunzawm harsa tihna i nei em?
3. Chhungte/thiante leh pawn lam thil tih khawm naah te tel harsa/hreawm i ti em?
4. Kha'ng hun lai khan thin ram/thinchhe zual bik in i inhria em?
5. A boral hnu thla thum (vel) chhung khan i hna ngai leh kalphung pangai te i chhunzawm thei em?
6. I hmangaih tak i chan avang khan i thin a rim em?
7. Kha'ng hunlai khan zan mut harsa i ti em?

PART – II: TUN HUN

Heng zawhna te hi tun hun a i lusunna chungchang a i dinhmun ngaihtuah chungin i chhang dawn nia.

1. A thihna chungchang i ngaihtuah in i la tap ngai em?
2. Amah i ngaihtuah hian thinrim na te i la nei ngai em?
3. A awm ta lo tih hi pawm harsa i ti em?
4. Ngaih ngawih ngaih chang ila nei thin em?
5. A chanchin i ngaihtuah chhuah hian i rilru a la tina ngai em?
6. I ngaihtuahna zawng zawng ala luahkhat em ? emaw Ila ngaihtuah fo em?
7. Amah i ngaihtuah changing a rukin i tap thin em ?/A ruka mittui tlak i nei ngai em?
8. I nuna a hmunruak hi thil eng emaw, tu in emaw/an la luah khat leh thei in i ring em?
9. Amah ngaihtuah lo hian i awm thei angem?
10. A thi ta mai hi lungawi thlak loh I ti em?

11. I bul vel ami te leh thil awm te hi amah a ngaihtuah chhuah tir tu che an la ni em?
12. A thi tawh tih hi i pawm thei nge thei lo?
13. Tun hnuah hian a awm tawh loh avangin i tah ala chhuak thin em ?

APPENDIX – D

Key Informant Interview Schedule

Church leaders:

1. Do you think that drug abuse is a sin?
2. Do you believe that Christianity condemns drug related deaths?
3. Is equality part of a crucial doctrine n Christianity?
4. How do you/your church give support to the bereaved families?
5. Have they come to you for counselling or support?
6. Is there any difference in conducting the funeral of a drug related death or deaths caused by illness?
7. How much involvement does the church contribute in the funeral and the practices that follow?

Community leaders:

1. Can you tell me the general community perception of a drug related death?
2. What are the rituals involved in funerals?
3. Are these traditional practices still practiced in communities across Mizoram?
4. Who is responsible in carrying out these responsibilities in time of death in the community?
5. Is there anything that differentiate a drug related death as compared to death caused by illnesses?
6. Is there any difference in the voluntary actions contributed by the community towards a drug related death and deaths caused by illnesses?
7. What kind of support have been given to the bereaved families?
8. Do you think that the support system needs to be improved?
9. What kind of social practices would you change in dealing with a drug related death (if any)

Appendix - E

Guide for Focus Group Discussion

Discussion 1: Abandonment/ Rejection (11 items)

1. Feel that the person never considered what the death might do to you.
2. Wonder about the person's motivation for not living longer.
3. Sense some feelings that the person had rejected you by dying.
4. Feel like the person chose to leave you.
5. Feel deserted by the person.
6. Feel that the death was somehow a deliberate abandonment of you.
7. Feel anger or resentment toward the person after death.
8. Feel that you should have somehow prevented the death.
9. Feel like you missed an early sign that may have indicated to you that the person was not going to be alive much longer.
10. Feel like the person was somehow getting even with you by dying.
11. Feel like the death somehow reflected negatively on you or your family.

Discussion 2: Stigmatization (10 items)

1. Feel like a social outcast.
2. Feel like no one cared to listen to you.
3. Feel that neighbours and in-laws did not offer enough concern.
4. Feel avoided by friends.
5. Think people were gossiping about you or the person.
6. Think that others didn't want you to talk about the death.
7. Feel somehow stigmatized by the death.
8. Feel like people were probably wondering about what kind of personal problems you and the person had experienced.
9. Think that people were uncomfortable offering their condolences to you.
10. Feel like the death somehow reflected negatively on you or your family.

Discussion 3: Search for Explanation (7 items)

1. Think that the person's time to die had not yet come.
2. Questions why the person had to die.
3. Feel that the death was a senseless and wasteful loss of life.
4. Find you couldn't stop thinking about how the death occurred.

5. Find yourself not accepting the fact that the death happened.
6. Feel like you would never be able to get over the death.
7. Try to find a good reason for the death.

Discussion 4: Guilt (6 items)

1. Think of times before the death when you could have made the person's life more pleasant.
2. Feel like there was something very important you wanted to make up for the person.
3. Feel like maybe you didn't care enough about the person.
4. Wished that you hadn't said or done certain things during your relationship with the person.
5. Feel somehow guilty after the death of the person.
6. Feel like you had made the person unhappy long before the death.

Discussion 5: Somatic Reaction (4 items)

1. Experience light-headedness, dizziness, or fainting.
2. Experience trembling, shaking, or twitching.
3. Experience nervousness.
4. Experience feeling sick.
5. Think that you should go see a doctor.

Discussion 6: Responsibility (5 items)

1. Feel like others may have blamed you for the death.
2. Feel that, had you somehow been a different person, the person would not have died.
3. Feel like the problem you and the person had together contributed to an untimely death.
4. Feel like the person had some kind of complaint against you at the time of the death.
5. Feel like you had made the person unhappy long before the death.

Discussion 7: Self-Destructive Orientation (6 items)

1. Worry that you might harm yourself.
2. Think of ending your own life.
3. Intentionally try to harm yourself.

4. Feel like you just didn’t care enough to take better care of yourself.
5. Feel like you just could not make it through another day.
6. Find yourself totally preoccupied while you were driving.

Discussion 8: Shame/Embarrassment (6 items)

1. Avoiding talking about the death of the person.
2. Feel uncomfortable revealing the cause of the death.
3. Feel embarrassed about the death.
4. Tell someone that the cause of death was something different than what it really was.
5. Avoid talking about the negative or unpleasant parts of your relationship.
6. Not mention the death to people you met casually.
7. Feel uncomfortable about meeting someone who knew you and the deceased.

Appendix – E
(Mizo Version)

Focus Group Discussion Guide

Sawiho tur - I: Inhnutchhiah/ Inhnawl (11 items)

1. Nangmah ngaihtuah miah lo leh a thihna khan nghawng lo tur che a ngaihtuahna
2. La dam ve reng a tum /duh ang em tia ngaihtuahna
3. A thihsan avang che hian ahnawl ta che ah i inngaihna
4. Duh reng vanga kalsan a i inngaihna
5. A thlauhthla tawp che a inhriatna
6. Engti kawng zawng emaw takin a thihna kha nangmah a hlamchhiah/hnutchhiahna ah che ngaihna
7. A thihna ah a chungah thinrimna leh ngainat loh na
8. A thihna kha pumpelh tir theiha ngaihna
9. A thihna pumpelh tir thei tur khan tih theih nei si a, hriat lawkna deuh neiah te in ngaiin, lo ti ta la tunah hian a la dam awm sia tih ngaihtuahna
10. A thungrulh duh vang chea thi ta ni a hriatna
11. A thihna hian in chhungkua ah mualphona a thlen a ngihna

Sawiho tur – II: Enhranna (10 items)

1. Khawtlangin an en hrang che a inngaihna
2. Mi in i thu sawi te an ngaih pawimawh sak lo che a ngaihna
3. Thenawm khawveng te leh chhungkhat ten an ngaihven lo che a ngaihna
4. Thian ten an enhrang/kawm duh loh phah che in hriatna
5. I chanchin mi ten sawiin an rel che a in ngaihna
6. A thihna chanchin hi mi in sawi tam lo la an ti che a inhriatna
7. A thihna leh thih dan te avang hian mi in an en hrang/hnualsuat che a inhriatna
8. In inkar a harsatna leh inhmuh thiamlohna avangte a tiang hi thleng anih leh nih loh mi ten an ngaihven ru riaua in hriatna

9. I lusunna mi ten an rawn tawmpui hreh riau chea inhriatna
10. A thihna hian in chhungkaw tan nghawng thalo a nei nia inhriatna

Sawiho tur – III: A chhan hriat tum a ngaihtuah/ngaihven (7 items)

1. A thih kha a la hun lo
2. A thih nachhan kha hriatthiam har ti a chhanna zawn
3. A boralna kha awmze neilo a ngaihna
4. A thih dan kha ngaihtuah loh har ti
5. Kha thihna kha a thleng ngei a ni tih pawh harsa ti
6. A thihna kha ngaia nei theilo
7. A thihna khan chhan tha tak nei tura ngaihna

Sawiho tur – IV: Mahni in thiamloh na (6 items)

1. A dam lai khan a nun nawmna thil lo tihsak tur naihtuahna
2. A lakah tih loh leh bat neia in ngaihna
3. Ngaihsak tur anga ngaihsak tawk lova inhriatna
4. A damlaia a chunga i thiltih leh sawia inchhirna
5. A thih hnu ah nangmah inthiamlohna
6. A damlai khan a nunah hlim loh na thlensak tua in ngaihna

Sawiho tur – V: Taksa lam a nghawng dan (4 items)

1. Luhai, lu zo lo riau a in ngaih leh chauh thutna
2. Tha khur emaw ngheh loh riau
3. Zam riau a in hriatna
4. Dam loh/awm nawm loh
5. Doctor hnena in entir rilruk

Sawiho tur – VI: Mawhphurhna (5 items)

1. A boral chungchanga midang puhna
2. A boral hma khan i mizia te lo danglam ta se a la dam phah a rinna
3. In inkar a harsatna awm thin te khan a thih chhanah nghawng neia inhriatna
4. A thih lai khan i lakah lungawi lohna neia hriatna
5. A damlai khan a nunah hlim loh na thlen thina in ngaihna

Sawiho tur – VII: Mahni intih chhiat/nat duhna (6 items)

1. Nangmah leh nangmah in tih nat mai hlauhawmna
2. Mahni nunna lak duhna

3. Tum lawk vang rengin nangmah leh nangmah in tihnat tumna
4. Mahni in enkawl hlamchhiah phah
5. Ni thar lo thlen a harsa tihna leh nun thlakhleh lohna neih
6. Lirthei i khalh lai ten rilru pe miah lova thil dang daih ngaihtuah chang neihna

Sawiho tur – VIII: Zahthlak/Mualphona (6 items)

1. A thih chanchin sawi loh dan hram ngaihtuah
2. A thih chhan sawi nuam ti lo
3. A thihna/thih dan kha zahthlak a ngaihna
4. Mi tu emaw tal hnenah a thihchhan diktak ni lovin chhan dang vang a thi anga sawi
5. In inkar a boruak thalo awm thin te kha mi bula sawi hreawm tihna
6. Thian hnai tak tak te ni lem lo bulah a thih chhan leh chanchin sawi ngai lo
7. A thih dan hrechiang tak te hmuhin awm ti nuamlo

APPENDIX - F

The Weeping Widow
(Mizo Version)

Ka pasal Peter-a nen kan inneih hian kan la naupang dun hle a, kei aiin kum khatin a upa na a kum sawmhnih kan la tlinglo ve ve a ni. Kan inneih hian thla li mi nau ka pai mek a ni. Kan in ngaihzawn dan chanchin hi sawi tur a tam ve hle a, kan inneih hma kum hnih vel khan kan thian te birthday lawmna a intawng kan ni a, min rawn be hmasa a kan in mil nghal hle a ni. Ka hmuh hmasak ber a ka hriat dan chuan kawm nuam leh fiamthu thiam tak ni in ka hria. Ka nu leh pa te hi an strict ve deuh avangin kan landline ah minlo be thin a, chutih lai chuan mobile phone te a la awm si lova ka nu te hriat hlau takin kan in be ve thin a ni.

Kar khat vel hnuah chuan kan in a lo leng turin ka sawm a, a rawn len hmasak ber zan chuan a zak em em a a tawng mang lova, darkar khat vel a lo len hnu ah chuan a haw leh mai a. A zan leh ah pawh lo leng tura ka sawm angin a lo leng leh a, khami zan kha chuan a zak lutuk te kha a reh deuh in ka hria, a tawng duh angreng hle in ka hria. Birthday lawmna a kan inhmuh a a mizia ang tho kha a ni leh a. Ka nu te pawh thingpui ka lum lai chuan a lo kawm bawrh bawrh a.

Kan in ngaizawng chho ve ta zel a, min duat thiam em avangin thla tam pawh a liam hma chuan ka ngaina telh telh a. Birthday lawm zan khan zu a in tih chu ka hre tho na in, ka nu in a rawn sawichhuah hma kha chuan damdawi a khawih ang tih chu ka ring ngai reng reng lo.

Tlai khat ka school bang chu ka nu hnenah Peter-a te nen thian hovin chaw kan eikhawm dawn tih ka hrilh a. Ka nu chuan fimkhur tur leh keima tan a thalo tur engmah ti lo turin min chah a. Peter-a’n min ngaihsak lo deuh anga a ngai ni a ka hriat avangin ka thin a rim a, ka nu pawh chu ka hnial let ve a. Ka nu chuan a rawn len chang hian zu rim nam si lova rui thin ni a a hriat thu a sawi a. Ka awih loh thu leh a hresual a nih ka rin thu in ka chhang a. Chumi zan kan chaw ei khawm chuan ka nu thusawi chu ka rilru ah a awm reng mai a. Peter-a lo len hmasak ber zan a a zah zia leh a zan leh mai a a mizia inthlak ta lutuk te chu ka ngaihtuah chhuak a. Hemi zan hi chuan Peter-a hi chik deuh hlek in ka en ta a, amah tak phei chuan zu pawh a in tamin ka hre lo, mahse a thian te chu an kut te a vun avangin damdawi anih ka ring deuha

Choka ah chuan ka thiante ho nen chuan chaw ei kan siam a, Peter-a chu a bo vang vang a chaw ei dawn a a rawn let leh chuan a mizia chu a rawn danglam leh ta daih a. Chutih lai tak chuan ka nu thusawi kha a dik palh mai ang tih hlauhna ka nei in, ka rilru a hah hle a. Chaw eikham chuan kan inah min thlah a, kan haw kawngah chuan damdawi a tih leh tih loh chu ka zawt ta tawp a, hreh tak chungin min chhang a, a ti chhin ve mai mai ni in a insawia. Party na velah chiah a tih thin thu leh ti tawh lo tura ka duh chuan a sim nghal mai tur thu min hrilh a. Ka duh loh zawng ani tih a hriat chuan a sim mai ang tih chu ka ring nghet bur a ni.

Thla hnih vel a liam hnu pawh chuan kan la hlim hle a, ka nu leh pa te chuan kan in ngaihzawn chu an phal lo tan ta viau a, ka nu chuan ka tan a thalo a tia, ka pa pawh chuan kan in a rawn len chu a phal tawh lova. Kan sikul bang hi a bike in min rawn lam a, kan thian te in velah kan leng kual thin a, in ah kan in hmu ngai ta lova. Ka hlim duh lo tu nia ka ngaih ka nu leh pa te ai chuan Peter-a lakah chuan ka in nghat tawp a,ka ring bawk a a bulah chuan ka thla a muang hle thin. Engkim kan in hrilh tawn vek a, ka nu ten kan in ngaihzawn an phallo chu hreawm a tih thu te leh an chhungkua an hlim loh thu te pawh min hrilh thin a. A pa chu zu ngawlvei zing atanga zu in thin anih thu te, a nu chuan a pa zu in chu a ngawih pui mai niin a sawi bawk a. Nau hmeichhia sikul kal lai ve tho a neih thu te, a pa awm loh hunah pawh anni chu a kuta awm an nih thu te a sawi thin a. A pa zu rui chuan a nu nen chuan a ti hreawmin a ti duhdah hle nia sawiin, kutte pawh a thlak hial thin tih a sawia. A pa zu rui laka a nu leh a nau venhim chu a mawhphurhna ah a ngai a, a rilru a hah in a thaw a pik thin hle a. A chang chuan chhuanlama hmangin zu a in phah thin a, kei pawn ka sawisel ngai lo. A chang hi chuan ka in thiamlo thin, a tirah khan damdawi a tih chu ka ringhlel thova, zu ka in ringawt atih khan ka lo awih zel maia, a tello a awm kha ka hlau em a, chan ka duh hlawl lo a ni. Damdawi tia puhin lo zawt ila, lo dik leh si lo ila, ka rinhlelh vang khan ka tih nat belhchhah angem? Lo ti tak tak si se ka nu leh pa leh ka chhungte kha an dik ani anga hmuh pawh min hmuh tir phal tawh awm si lova. Heng zawhna te hian thla thum chhung vel chu min tibuai hle a, ka zawt ngam thin lo, mahse ka zawh a ngai si, a chhan chu kum khat leh a chanve vel kan in ngaizawng tawh a, doctor hnenah kar tir lam a ka in entir khan, nau thla hnih mi vel ka pai tih min lo hrilh a.

Tlai khat chu kan inah a rawn kal a. ka lo zam in ka lo phili deuh a niang diklo a awm leh awm loh min zawt a, *“i fa ka pai”* ka tia. Hriatthiam loh hmel lutuka min

zawh nawn leh chuan *“ka rai a”* ka ti leh ta a. Mak tih hmel deuh phur deuh si hian a awm a, nau ka pai chu a tha a tih thu leh ka nu leh pa te pawn kan in ngaihzawn chu an pawm phah theih a ringa, an remtihna thlap a kan inneih theih mai a rin thu te chuan min thlamuan hle a. A phur lutuk chu mak ka ti zawk a, ka nu leh pa remtihna a ngaih pawimawh zia te, tin inneih a sawi phei kha chuan min hmangaih hle in ka hria a, ka thla ati muang em em ani.

Min nei duh a keimah nena chhungkaw din a duh tih ka hriat a ka lawm zia kha aw! Mahse a tak ramah chuan tleirawl in ngaizawng mai, sikul kal lai, naute neih pawh la ngaihtuah ngailo tan chuan kan thil tawn chu remruat lawk miah loh thil a ni a. Kan nu leh pa te hrilh dan tur pawh takngial pawh la ngaihtuah chhuak lo kan ni si a.

A tuk kan sikul bang chu Peter-a hian ka thiante zinga ka kal chu min rawn pawt hranga. Ngati nge ka tih chuan *“tih dan tur ka hria, zaninah in ru ang”* a ti ta a. Nidangah pawh kan lo ngaihtuah ve tawh thil a ni. Ka nu leh pa ten in ngaihzawn an phal loh avang hian kan in ru daih dawn nia, awm dun an phalloh chuan kan ti fiamthu thin a, mahse inrukna chhan tur em em kan nei lo bawk a kan inru chuang lova. Mahse nau ka pai tih kan in hriat atang kha chuan inruk chu thil tih awm ber niin a lang ta a. Midang te pawh inruk hnua innei kan hre ve teuh a, chhungte’n in ngaihzawn leh inneih an phalloh ho reng reng chu an inru a, an chhungte tan inneihtir mai loh chu tih ngaihna dang a awm tawh lo thin a, keini pawh chutianga tih ve chu kan tum ta a.

Kan chhungten min pawh then luih loh nan naute kan lo nei ve dawn bawk nen, nu leh pa te remtihna a kan inneih theih nan a tha dawn bawk si. Chuvangin inruk a sawi chuan keichu ka hlim zawk phian a. Zanah ka nu te mut hnu dar kua velah min rawn lam turin kan intiam ta a. Kan tum ang ngei chuan chumi zan chuan ka thawmhnaw chu bag-a ak chhuak chungin kan kawngkapui zawi teiin ka hawng a, kan thenawm dawr te ah chuan Peter-a chuan minlo nghak a, kan kal dun ta a.

Kan inruk atanga thla hnih hnu velah chuan kan chhungte chuan inneih min remtih sak ve taa. Ka naute pai pawh thla li mi a ni ve tawh a, kan inneih hnu chuan Peter-a nu leh pa te nen kan cheng ho a, sikul kan kal zawm tawh lova, Peter-a chuan computer class te kal a. Harsatna kan ngaihtuah thiam phak loh kan tawng chho tan ta ani. Peter-a pa chuan zu a in chhunzawm renga, zan tin deuhthaw hian Peter-a leh a

nu chu kut athlak thina. A zurui ang chuan Peter-a chu thawhchhuah nei lova nupui nei anih avangin a nupui leh a fa chu an enkawlsak a ngaia, chuvangin a nu leh pa te tan phurrit ani tiin in atang chuan a hnawtchhuak fo thin a. Peter-a hi mi khawngaihna ngah tak a ni a, a pa chu a zah thiam em ema, a zurui ang pawh chu a chhanglet ngai lova. Peter-a nu pawh chuan a pa chu ang reng lo turin leh a fapa tan a entawn tlaka nung turin a ti thin a. Pangai thei ang bera awm zui ve zel chu kan tum zantina, tlai khat chu Peter-a pa zurui lo haw chuan ka eirawngbawl lai chu min rawn an khum hrep maia, a fapa leh chhungkaw tihbuai tum ah leh an fapa thluaksuk saka, bumthlua nei ta ah min puha. Room atanga Peter-a alo chhuah chuan kei chu ka lo tap zawih zawiha, hemi tum hian Peter-a chuan a pa chu a vawikhatna atan a chhanglet ve a ni. Peter-a chuan a pa chu amah vanga zu in leh damdawi pawh khawih anih thu te, min neih avanga a nuna thil tha tih duh anih thute a sawia. Peter-a chuan kan room-ah min hruai a, ka thawmhnaw bag-ah min pack saka, a pa nena an inkar a fel hma ni hnih khat chu ka nute in lama lo awm turin min ti a.

Kar hnih vel chu phone a kan in biak bak chu Peter-a nen chuan kan inhmu miah lova, engtikah nge min rawn hruai dawn ka tih chuan *“lo la awm lawk rawh”* a ti zel a. Kar hnih hnu ah chuan Peter-a chu alo kal ta a, amah chu a landanah ringawt pawh ka hmuh hnuhnun ber nena tehkhin chuan a danglam em em a. A ruih hmel hle bakah a chauh hmel em em a, hemi ni hi chuan damdawi a rui tih ka chiang hle. A rui lutuk chu din pawh a ding tha thei lova, zu rim a nam miah bawk si lo. A ruala haw ve tur chuan min ti ta a, han in ngaihtuahna hun vak pawh a awm lova, kawngpuiah chuan taxi in min nghak reng tawh a. Amaha ka haw tir chuan ka ngaihtuah dawn lutuk bakah Peter-a pa chuan engtin pawh lo til eh se se ka chhan hun ani ve tawh tih rilru pu chung chuan inchhunga ka thawmhnaw dah te chu va la in hmanhmawh tak chuan ka zui haw ve ta a.

Khatiang zawng zawng kha tumah ka hrilh ngai lova, a chhan chu ka nu chuan Peter-a chu a la duh lo lutuk a, ka pa hi chu a tawng tlem ve hrim hrim bawk nen. Peter-a damdawi a khawih chhan chu tunah chuan intihhlimna ni tawh lovin a khawvel kal bosan nan a ni. Tih ngaihna pawh ka hre lova, naute neih hun a ni ve tep tawh bawk sin en, thla sarihna ka pai mek a, a chang chuan zan hnih zan thum te alo haw lo thina, a chhan chu alo haw veleh hian a pa hian a tangkailo leh laktlakloh tawp ah ain ngaihna tur khawp hian alo an khum zel si a.

Kum sawmhnih pawh a la tling em lova, fa nei mai tur ani bawk si, hnathawh la nei bawk si lo nen a tan chuan a hautak in a hahthlak tham em a ni. Peter-a chuan a pa a chunga a sual loh chuan a nu leh pa te bula awm chu a pawi a til ova, a pa hnaih lo thei ang berin awm a tum zel a, a chhan chu naute nena thlamuang taka kana wm theihna kawng nia a hriat vang a ni. In leh a velah chuan tangkai thei ang bera awm a tum tlata, amah hian thil siam te hi a thiamine, a thiante pawhin an computer leh bike thalo lai te chu man neiin an rawn siamtir ve fo thin a. A thian lokal te chu zui chhuaka rawn ruih chang an nei thin a, mahse a ruih pawhin tu chungah mah a sual ngai lo. Kan naute lo pian hnu phei chuan Peter-a chuan a hnathawhna turin ama pualin computer leina tur alo khawl ngah ve tawh a. Computer certificate a neih veleh hna ka zawng ang tiin a phur hle thin a ni.

Thla hnih khat hnuah chuan Peter-a chuan computer dawrah hna a hmu ta a, a thawk ve ta a. A hlawh chu tamlo mah se kan naute enkawl nan chuan a tawk hle a. Peter-a nu chu *"pi"* a nita chu a lawm em em a, kei leh kan naute pawh min duat thin hle a ni. Peter-a pa pawh chuan naute chu a pawm ve mai a, inah a awm tam leh lo na a. Kan naute neih atang chuan kan chhungkua pawh chu kan hlim chho ta riau a. Peter-a'n damdawi tello nu a harsat deuh tih loh ah chuan. Kan chhungkaw chuan Peter-a'n a damdawi a tih chu a lo ngai viau tawh a ni tih kan hrethiam ta mai a. Diazepam leh nitrosun an tih ang kha kum khat leh a chanve vel chu a khawih a, chumi hnu ah chuan Parvon Spas a inchiu a ching chho ve leh ta a.

Kan fapa pawh kum thum a tling ve tep tawh a, Peter-a nau leh a nu nen chuan a damdawi tih chungchang chu engemaw tal tih tha in kan hria a. Peter-a nu chuan a damdawi tih chu kan hria a, kan pawm theilo tih a hrilh ta a,Petera chu a tang na hle a, intih hlim nan chauha damdawi hmang niin a insawi a. A nau ve thung chuan aman thudik chu a hrechiang bera insiam that a hun tawh ani tiin a hrilh ve a. Peter-a nu chuan a fapa pawh alo lian ve zel anga, a tupa in pa *"addict"* a thanlen pui tur chu a duh loh thu leh Peter-a pawn a pawi tur zia a hriatthiam vek thu a sawi a. Kan vai chuan damdawi sim a tum phawt chuan kan theih ang tawkin kan tanpui a mamawh na ah kan puih tur thu kan sawi hlawm a.

Hun alo kal zel a, Peter-a tan chuan damdawi tih loh tawp chu a har hle a, a chhan chu a *suffer (withdrawal sumptoms)* nasa thin hle a. Tichuan kan vai chuan damdawi tih ai chuan zu in chu a tha zawk kan ti vek a. Peter-a chuan zu a in ta zawk

a. Reilo teah chuan zu ngawl chu a vei ta mai a, a damdawi tihna ah a taksa alo chaklo tawh bawk nen a zu in chuan a hriselna a khawih chhe nasa hle a.

Kum hnih khat hnuah chuan Peter-a chuan damdawih a khawih leh ta a. Alprozolam leh khuh damdawi te a ti ber a, zu pawh a thlah chuang lova. A pa nena an inkar pawh a buai chho leh ta a. An in hau chu tun hma zawng aiin a nasa tawh a, a chhan chu an pahnihin an ruih ve ve bakah an pahnih chuan a tlawm zawkah an tang duhlo ve ve a. A chang phei chuan an in hau chu an insual a, thelh an ngai hial thin a ni.

A kum leh ah chuan a vawikhatna atan Peter-a chu damdawiinah admit a ni a. Natna neuh neuh dang bakah thi in a luak a (internal bleeding). Doctor te chuan a damdawi tih leh damdawi ei chi alo khawih rei tawh avang chuan a pumpui chu a chhe nasa hle a, damdawi tih leh zu in a chhunzawm zel chuan a nunna atan a hlauhawm tawh thu leh thihna hial pawh a thlen thei mai ang tih an hlauhthawn pui zia chu an sawi ta a. Chutia an enkawl a a dam that deuh hnu chuan kan chhuak ve ta a.

A hospital chhuah hnu thla nga vel chu ruihtheih thil a khawih miah lova, amah pawn harsa a ti hle a, krismas boruak vel chu tih leh chhuanlam ah hmagin a rui leh tan ta a. Rui chungin alo haw thin a, zan a lo haw loh te pawh a nei thin. Engemaw chenah chuan ngaiah kan nei ve deuh tawh a, kan thla pawh a phang em em chuang lo. Pangai takin a rawn haw ve leh mai thin a, a harsa ka tih ber chu alo haw loh chang hian Bawihtea hian a pa awmna min zawt thin a chhan ngaihna ka hre ngailo.

Kumthar kum tir velah chuan Peter-a chu internal bleeding vang tho chuan damdawiin ah kan admit leh a, hun engemaw chen kan awm hnu chuan kan chhuah alo hun ve leh ta a, kan chhuah dawn tukah chuan kan fapa chu phone-ah bia in tlai a sikul ban hunah chuan inah alo hmuah dawn thu te, chocolate leh sweets te alo hawn sak dawn thu te a hrilh a, an hlim dun hle mai. Kan fapa pawh chu a phur em em a, a pa in a hmangaih em vang ni berin ka hria. Peter-a hian kan fapa chungah hian aw ka vin a hmang ngai miah lova, a dawhthei em em thin. Hna thawka a chhuah emaw, thian hoa an chhuaha an ruih viau pawh hian thil hawn a theihnghilh ngai lova, a rui lai hmu lo turin a fimkhur hle thin.

Damdawiin atanga kan chhuah dawn zingah chuan doctor chuan Peter-a chu a dinhmun a thalo hle a, ruihtheihthil a khawih zawm leh chuan a kawchhung chu alo chhiat nasat tawh em avangin a taksa in a zo tawh loh a hlauhawm thu a hrilh a, kan fiah ta kuarh ni ber in ka hria.

Damdawiin kan chhuah atanga thla khat dawn a vei hnu chuan, tlai khat kan chaw killai in Peter-a pa zurui chuan Peter-a bawk chu a tawng leh ta a. Chhungkaw sum harsatna te chu Peter-a puh leh ta a, a nupui (Peter-a nu) chuan a fapa chu damdawi leina tur pe thin lo sela chuan 'addict' pawh ani lovang a ti a. a nu leh keimah chuan Peter-a chu kan duat lutuk vang niin min puh bawk a. An inhnial hrep hnu chuan Peter-a chu thinrim lutukin in atangin a chhuak a. A pi hnenah Bawihtea chu ka dah a, a pa zawng tur chuan ka chhuak ta a. Kan thenawm vela a thiante in ka en kual a, ka hmu bawk si lova, ka haw leh ta ringawt a. Peter-a chuan kan ngaihtuah ngam loh khawpa thil thalo a ti ang tih ka hlauin ka ngaihtuah hle a, mahse lo nghah tawp mai loh chu tih theih dang ka nei si lo. Bawihtea ka tih mut lai vel chuan Peter-a chu alo hawa, zu a rawn in leh tih chu ka maia, mahse tih thinrim belhchhah ka duh loh avangin engmah ka zawt lo. A intifaia, kan bulah chuan a rawn mua, a pa chungah chauh lo chuan tu chungah mah a thinrim loh thu min hrilh a. Min hruai bo daih thei se chuan min hruaibo daih a duh thu a sawi a, mahse a nu leh a nau a ngaihtuah bawk si. Engkim a tha leh vek mai ang tiin ka theih ang tawk chuan ka hnem ve a.

Chumi zan dar khat velah chuan bathroom atang thawm ring tak a rawn ri dut mai ka hriaa, rang takin ka tho nghala, Peter-a chu ka bulah alo mu tawh loa, hmanhmawh takin bathroom lam pan chuan ka tlan pheia, kawngka chu alo in kalh loh avangin ka nam hawng a, Peter-a chu ka va hmu thei a. Bathroom chhuatah chuan alo thaw dep depa, a banah chuan kan fapa mut kekawra vuah tura ka tih elastic chu lo inhrengin a bul chhuatah chuan inchiuna te a lo awm nuaih mai a, a bulah chuan thingthi in a lu ka malchunga hlang pah chuan min tanpui tur ko in ka au ta vak vak a.

Ka au thawm velah chuan Bawihtea pawh chu alo harh a, a rawn tap ve bawk a, Peter-a nu leh a nau chu kan roomah chuan an rawn tlan lut a. Sawi tur pawh ka hre lo, kan room a kan zawn phei lai te chuan Peter-a chu ka ko char char a, a harh nge harh lo pawh ka chiang lo, mahse ka kutah chuan nghet takin min vuan tlat a.

Peter-a pa chu thenawmte kai tho turin a chhuak a, a nu nen chuan a bulah kan thu a, a awmah te tih harh tumin kan nam a, tih dan tur tha ber ni a ka ngaih avangin a

ka ah te chuan ka zuk thaw lut a, ka phili vek tawh a enge tiha, tih loh tur pawh ka hre lo, mahse han thawk luh kha a that ka ring a. Bawihtea chu a ni chuan an room lamah a la phei a, kan thenawm ho pawh chu anlo lut ta a. Peter-a chu car-ah kan hlang lut a. Damdawiin kalkawngah chuan a bulah ka thu a, min ngheng a, keiin ka kuah a. Nikhua a hria chuan ka hre tawh lo, mahse ka kut chu nghet takin a vuan tlat a.

Minute hnih hnu velah chuan a thaw chu a tawp tih ka hria a, ka kut a vawn pawh chu zawi te hian a thlah ta riai riai a. Ka ring ngam hlawl lova, a hming chuan ka ko a, mahse min chhang lo. Hospital emergency kan thlen hnu chuan Peter-a nu nen chuan kan tap a, kan thenawm minlo zui tu te leh hospital a thawkte chuan damdawiinah chuan an zawn lut ta a. Emergency room kan va thlen chuan doctor chuan engmah tih theih an neih tawh loh thu leh chhan tlak a awm tawh loh thu in min lo hrilh a. Bathrooma ka va hmuh dan min zawt a, ka hmuh dan chu ka hrilh a, spasmoproxyvon dose sang taka a in chiu avanga overdose a thi ani tih a chiang ta a.

Khami hnu a thil tleng kha chu ka hre chiang meuh tawh lo,tun thleng hian a thihna leh a vuina zawng zawng phei chu ka mumang ang mai niin ka la hria. Khawtlang leh kohhran anga tih tur hrang hrang kha an ti a. A zan hmasa zan hnihah chuan thalai ho an lo kalkhawm a, a dawt leh zanah chuan upa ho deuh anlo leng leh a. Kan chungah an tha in kan chhungkaw tana an tawngtai tur thu te min hrilh hlawm a. Peter-a thiante pawh an lo leng thin a, a chanchinte sawiin thian tha tak a nih zia te, pasal tha tak nupui fanau ngaihtuah mi a nih zia te, pa tha tak anih zia te leh mi tha leh ngilnei tak anih zia te min rawn hrilh nawn leh thin a. A thian thenkhatte chuan Peter-a pa hi an dem thina, a enkawl dana an thinrim zia te leh an lungawi lohna te an rawn sawi thin. Peter-a hretu tam zawk te hian a damdawi tih hi an dem lova, a chhungte leh thiante hmangaih em em tu niin an hre reng a ni. A vuina hun leh engkimah lungawi lohna ka neilo, thenawm leh thiante leh kan laina te pawn min tawrhpui hle a, mahse engemaw hi kim lo tlai niin ka hria a, Peter-a pawh a ni mahna. Thihchhan ah chuan “overdose” tiin a inziak a. Ka en apiang hian ka thin a rim thar ziaha, ka pasal ka khawngaih bawk si. A thih chhan hi ka mi hriat Peter-a nen kha chuan danglam tak a ni. Dawtte pawh a ang lek lek zawk. Bawihtea nena kan tana a thatna zawng zawng leh min hmangaih zia te ka ngaihtuah hian Overdose a thi tih hi in mil ka ti thei lova, dik ka ti thei hek lo.Nun hian a phatsan chiang hle in ka hria a, naupang taka a thi mai leh hma hun thlir tur ngah taka nunna a chant a hian ka thin a ti ur em em a ni.

Tun thleng hian a thian ten Peter-a'n a chhungte a ngaihsak zia an sawi thin hi tun thleng hian ngaihthlak huam ka la ti thin. A chang chuan a awm tawh lo tih hi rin a harsa ka la ti hle thina. Engemaw chenah chuan a pa in a tih dan te kha ka dem thin a, mahse keimah pawh ka in dem ve tho, an inhauh nikhua te khan lo chhan ve thin ila chuan mal lutuk niin a in ngailo tur te ka ti a. Bawihtea ka en a a pa min hriatchhuah tir nasa hle a, computer lama a tuina leh a thiam theih dan te, leh thil dang tamtakah pawh a pa nena an in an na te ka hmu a, a thang lian hi hmu turin Peter-a hi la dam se ka ti tak tak a ni.

A thi tih pawm tur hian hun rei tak ka duha, Krismas boruak a rawn ni chho a, Peter-a nu in Christmas dawn a incheina vel a rawn leia, Peter-a thlan pawh rawng hnawih that te a rawt a. A tirah chuan pawm har ka ti lutuka, a thlan kan chei zo kan haw chu inah darkar fe ka tap a ni.

A thih atangin kum kua dawn a ni tawha, a sulhnu hi engtikah mah ka hlamchhiahin ka theihnghilh tawh lovang. Awm tawh lo mahse a pa sulhnu leh a pa chanchin te chu Bawihtea chu a tam thei ang ber hriattir ka tum thin a. Mi tamtak chuan pasal nei leh a Bawihtea pawh min enkawl pui tur neih leh tha min tih puia mahse kan la naupan viau laia Peter-a nena kan lo suangtuah ve thin chu tih hlawhtlin ka la tum reng a ni. Tun thleng hian Peter-a te in ah a nu leh pa ten en kan la cheng ho a,tunah chuan Bawihtea enkawlna tur pawh hlawh te ka nei ve tawh a ni. Eng emaw chang chuan Peter-a thihna ah hian a pa hi ka dem ve thin a mahse tunah chuan a hma anglo takin ka hrethiam chho ve ta in ka hria. A zu ngawlveina hian a thatna zawng zawng te hi lak sakin a nunphung leh mizia te pawh a thlak danglam sak niin ka pawm thei tawh a ni.

APPENDIX - G

The Praying Mother
(Mizo Version)

Ka pasal kha sawrkar hnathawk a ni a, thingtlangah a awm thin a, kei chuan ka nu te in bulah thingpui dawr siamin ka nghak ve thin a. Ka pasal in nupui dang min neihsan hian ka fa pathum te nen ka nu te chu kan fin leh a, khami hnu kha chuan mahni ke a dina, midang tibuai lova awm theih chu ka tum em em a ni. Ka fapa upa ber Robert-a chuan middle sikul a tan ve chiah a, a nau te chu primary sikul kal lai ni in, ka fa te zinga naupang ber chuan sikul a la tan ve dawn chiah a.

Ka nu leh pa te chu kan unau zinga naupang ber chuan ala awmpui a, eichawp dawr an nei a chu chu an eizawnna bulpui ber a ni. Kan eizawnna chu kan ti lian ve zel a, kan veng chhunga dawrkai lian ber kan nit a a. Kan veng a mi tam zawk te chu thingtlang atanga Aizawla rawn pem lut an ni. Kan nupa inthen atangin kum thum liam ta a, Robert-a pawh naupang fel tak niin sikul chawlh lai te hian a nau te nen kan dawrah min pui nasa thin em em a. An unau zinga upa ber ani bawka, Robert-a chu a puitlingin a nau te pawh a ngaihsak em em a. An sikula a thiante'n sikul chawlh laia an zinga inkhel loa dawr a nghak thin chu an chhaih chang te hian *"puitling ka ni tawh a naupang bula infiamna hun ka nei lo"* ti in alo chhang mai thin.

Hetiang hunlai vel hian thalai zingah damdawi tih chu a hluar tan hle a. Kan venga rawn in sawn thar te chu damdawi tawlhru an ni tih kan hria a, heng vang te hi aniang kan veng chhungah pawh damdawi ti an awm nuala. Thil inthlak danglam chiang taka ka la hriat reng chu Robert-a pawh chu rawlthar (luhlul rual) a ni chho ve tawh a, pawn lamah thiante pawh a kawm thina, keipawh chuan ina min pui thin hi ka khawngaih thin avangin a thiante nena inkawm tur pawn ka ti ve thin a. Thian thar siam chu a tan thil har a ni lem lova, kum tawp lamah chuan a mizia pawh a inthlak viau tawh tih a hhriattheih.

Robert-a leh a thiante chuan kan veng field bul velah mei an zu ru thin tih min hrilh a. Tlaikhat alo haw chu a kalna ka zawt a, field ah an kal thu in min chhang a, miin mei an zu thin tih min hrilh chu ka sawi ta a, engtin mah min chhang lova, thudik anih ka ring ta mai a. Naupangin meizuk chu ka remtih loh thu leh a nau te entawn tlaka upa ber a nih anga puitling taka awm turin ka fuih a.

A kar leh ah chuan a thiante ho nen dawrah an rawn kal a, football tournament-a tel ve turin min rawn dil a, thilsual an tih dawn loh chuan tel ka phal thu ka hrilh a. Naupang sikul chawlh hmang an ni bawk a an tel duh chuan tha pawh ka ti hle tho a.

Tlai khat chu chaw ei dawn pawhin Robert-a chu a rawn la haw lova, chaw ei hma hian chhung inkhawm kan neih ziah avangin a tello ngai lova, a rawn haw lo hi mak kan ti hle a ni. Rei vaklo kan nghah hnuah pawh a la rawn haw loh avangin a putea chuan lo tih san mai a rawt a, a tello chuan kan lo inkhawm a, chaw pawh kan lo eisan a, chaw eikham hnu rei vak lovah chuan chauh hmel deuh tak hian a rawn haw a, a mu tlang nghal daiha.

Kum hnih vel aliam hnu chuan Robert-a chu football ah chuan a tui thar ta riau aniang, tlai tin an sikul ban apiangin an thiante nen inkhel turin an kal ziah a, hun alo kal zeal a mizia pawh chu hmuhtheih khawpin a inthlak nasa tawh a. A naute bulah pawh a awm hman meuh tawh lova, chhuahna tur hi a zawng reng mai a. Dawrah te chuan min pui ngai tawh lova. Nu ho chu kan ni vek a, keipawh, ka rilru a thil dik lo a awm aniang tiin ka rilru chu a hah ve hle a, mahse thangthat ted an aniang tih te, rawlthar zia aniang, a tha leh mai ang tiin ka ngaihtuah hram hram thin a.

A kum leh chu Robert-a'n damdawi a tih chungchang chu ka vawikhat hriatna ani. Kan venga a rualpui tam tak ten damdawia inchiu an chin avang chuan a hma atang pawn hlauhthawnna chu ka nei tawh a, mahse ka fapa chu a puitlinga, a tih ve duh ka ring ngai reng reng lova. Mi sawi ka hriat tirh chuan ka thinrimin ka rilru pawh a buai hle a, ka nu leh pa te leh ka nau ten en chuan zawh fiah chu tha kan ti tlang a.

Tlai khat a rawn haw chu kan tih dan pangaiin chhung inkhawm kan nei leh a, chutah chuan ka pa chuan Robert-a chu miin damdawi ti thin nia an sawi thu leh chutiang a awm chu kan chhungin rem kan tih loh thu a sawi a, Robert-a chu a thinrim em em a, chutianga kan ti chu a hua in damdawi ti a puhna pawh chu a pha nasa in, damdawi ti ngai reng reng lo niin a insawi a. Kar khat pawh a tlin hma chuan ka in tifelin, insuk tur te ka lak khawmnaah chuan Robert-a'n a hma ni lawk a a hak jeans kekawr atang chuan polythene te reuhte a thil fun hi a rawn tla chhuak nawlh mai a. Ka chhar a ka en chian chuan ka lo hlauhthawn ang ngeiin, syringe hmanhnu leh bottle chin leh damdawi (proxyvon) an hman hnu a ruak hi alo awm raih mai a. Chutah tak chuan ka fapa chuan damdawi ati ve ngei ani tih chu ka chiang ta, nilo se

chuan khatiang thil kha a kekawr ipte ah a awm lo tawp ang tih te chu ka ngaihtuah a. A putea roomah chuan ka va lut a, ka thil hmuh chu ka va hrilh a, ani chuan Robert-a chu zawh chian a, a taksa ah inchiuna hnuhma a awm em tih enfiah chu tha in kan hriaa, amah pawh thudik tak sawi tir kan tum ta a.

Chumi zan chuan aputea nen chuan Robert-a roomah chuan kan va lut a, a putea chuan chhun lama kan thil chhar chu a dawhkanah chuan va daha enge a nih leh a chhunga awm chu a hriat leh hriat loh zawt ta a. Robert-a chuan ala hmuh ngai miah loh thu leh a chhungah chuan enge awm pawh a hriat loh thu a sawi a. Kei chuan chhun lama ka thil tifelin a jeans ipte atanga tla ka chhar anih thu ka sawi a, Robert-a chu a ngawi hmak a, a putea chuan inchiuna hnuhma a taksa ah a awm leh awm loh a enfiah sak nghal a. Kei chuan a sirah chuan ngawi rengin ka lo tawngtai a, Robert-a thusawi te chu dik hlauh se a putea chuan inchiuna hnuhma chu hmu lo se ka tih lai chuan a putea chuan min rawn ko a , a kap bawr velah chuan inchiuna hnuhma alo tam mai a. Robert-a pawh chu a tang ngam ta lova. Zawhna hlirin ka khat a, engtik atang nge a tih tan a, enga tinge a tih…eng chen nge a tih tawh anga engtia ti tan nge niang le tih te chu ka inzawt mawlh mawlh a.

Ka fapa tlangval pawh la ni em lo, hmanni lawka dawrah te min pui tu kha drug addict ani ang tih hi pawm har ka ti lutuk. Ka tawngtai sak thin a, Pathian hnenah atan leh ka tan ngaihdam ka dil fo thin a. Nu ka nih na angin ka tih tur ka hlawhchham niin ka hria a, tih dik leh ka duh tak zet a ni.

Kan hriat zel danah chuan Robert-a chuan kan dawr atangin pawisa a ru a, a thiante nen damdawn lei nan anlo hmang thin a ni awm e. Veng te a awm kan nite chu kan tan chuan a pawi zual emawni, Robert-a chu a damdawi tih avangin an sikul atang chuan hnawhchhuah ani a, sikul danga luh kan tumin an phal tawh bawk si lo. In a awma ka fapa ven chu ka hna pui ber alo nita a, a chhan chu in atang hian a lo tlan bo anga thil thalo alo ti pal hang tih ka hlauh vang a ni.

Robert-a damdawi tih chu buaipui a ngai nasa telh telh a, enkawl dan tur pawh ka van viau tawh tih ah chuan ka nau thingtlanga pasal neia awm chuan an bula an hruai theih thu chu min rawn hrilh a. Thingtlangah chuan damdawi tih tur pawh a awm loh kan beisei avangin an bula awm chu atan a tha ang kan tia, chumi kum chu a nutei te bulah chuan a awm ta a.

Kum khat chuang damdawi a khawih tawh loh hnuah chuan Robert-a chu a rawn haw a, mhse rei lote hnuah chuan damdawi chu a khawih chhunzawm leh ta mai a. Damdawi a khawihloh na hian kan theihtawp kan chhuah ve a, addict centre hmun hrang hrang, Mizoram pawnah te, ram chhunga kohhranin damdawi ti ho enkawlna an siam (camping etc) ah te kan dah kual thleh thluah a, reilo te chu an nghei ve zawka, mahse a tlukna ngaihah bawk a tlu leh thin a, a boral hma kha chu hetiang hi kan awm dan a ni ta reng a ni.

A boral tuk chuan nidanga ka tih thin ang thoin dawr hawng turin zing dar ruk velak ka tho leh a, khua a vawh em avangin choka ah thingpui va in lum hmasa turin ka phei a. Robert-a room ka kal pelh lai chuan a room in hawng chu ka hmu a,a thawh hma ngaih loh avangin ka mit ala deuh a. Zanah a tho anga a room kawngka a kalh theihnghilh ani ang ka ti rilru a. A room kawngka khar that ka tum lai chuan a blanket chhuata tla chu ka va hmu a, a kawngka ka hawn zau deuh pah chuan Robert-a chhuata lo let reng mai chu ka hmu a. A dang in a vawh hmel em em a, a mit pawh a chhing vek a. January khaw vawt ah enge maw chhuatah a tih le tih zawhna chu ka in zawt a. A bulah chuan ka va kal hnai a, kaih thawh ka han tum a, a darah chuan ka han sawi a, mahse alo vawt vek tawh a. A lo thi fel der tawh a ni. Mah se ka awih theih tlat loh avangin khawvawtin a taksa chu a hmer vawt mai mai a ni ang ka ti a, tih harh tuma ka sawi pah chuan ka ko vak vak a, blanket te chu ka sin that tir a mahse min chhang tur a awm tawh lo. A hnu lawk ah chuan ka nu te leh ka unaupa te chu Robert-a nau te nen chuan an rawn tlan lut a,. A putea chuan a mar a’n dek a, Robert-a chu chhan tlak a awm tawh lo tih min hrilh ta a. Ka fapa chu a boral ang tih chu ka ring thei mai lova, tah pawh ka tap thei lo a ni.

Chumi ni chawhnu dar khat ah chuan kan vui liam ta a, engkim kha a thleng rang mah mah lutuk a. Robert-a thi tih pawh ka rin ngam hma chuan phum a ni a, vui liam a ni der tawh a, a puala hun hnuhnung pawh kan hmang zo der mai a. Reilo te tal kan zingah la awm thei se ka duh hle a, a chhan chu amah en khan tui taka mu rawn harh leh mai tur kha a ang lutuk a. A room reh riai mai te, chhung inkhawmna a a awm ve ta lo te, chaw ei dawhkan kan kil ho ngai reng reng ta lo te chu Robert-a a awm tawh lova a thi tawh ani tih min htiat nawn tir fo tu te an ni.

A thi tih hi pawm ka harsat na em em chu a rang lutuk kha a ni ber. Fapa addict han heih takah chuan enge maw chang chuan thil hi danglam se tihna te ka nei

thin a, a ruih a a thiante nena dan kalh zawnga an han chet ngat phei hi chuan ka thinrim lutuk hian awm tawhlo mai se emaw, awm bo daih se tihna te hi ka nei rum rum thin. Mahse chuan ka thil ngaihtuah thin chu ka rinloh lutuk leh rang lutukin min han thawng thut mai a, chutianga ngaihtuahna ka lo sen thin avang chuan ka in dem hle ani. Mahse Pathian hnenah ka fapa thil tih sual zawng zawng avang te khan ngaihdam ka dilsak a, a damdawi tih chhan leh addict alo nih chhan pawh hi a nu ka nihna a ka tlin tawk loh vang leh ka hlawhchham vang ni in ka hria. Chutiang ngaihtuahna chu a lo lut fo a, mahse nu dang zawng zawng ang bawkin ka fapa tana tha ber ka duksak a, tih ngaihna ka hriat loh chang hi chuan an tan ka tawngtai sak leh mai thin.

Pathian in Robert-a fapa atana min pe hi ka lawm a, midang ngaihdan chu ni ve kher lo mahse, ka fapa hian damdawi ti lovin mi fa te angin lo fel ve ni ta se, tuna Pathian ka hnaih ang hian ka hnaih kher lovang. A boral atangin kum nga lai a liam tawh a, Pathian hnenah a thlarau ngaidam tur hian nitin ka la tawngtai hmaih ngai lo. Robert-a hi ka tan chuan mi chhandamtu ani a, amah vang hian Pathian ka rinna hi tih chakin a awm ani. Mi te chuan ka fapa overdose a thi chu mi tha ani lovang, chhungkaw tana buaina thlen bak engmah ti lo leh lak tlakloh ah ngai mahse keia tan chuan Robert-a hi Pathian min hnaih tir tu a ni tlat a ni.

Mi nu te chuan an fate hna thawhna ah te an hlawhtlin in an chhuang thin a, ka thiamlo miah lo, nu te chuan kan fa te chu kan chhuang theuh a ni. Ka fapa chu khawtlangin mi hlawhtling an tih ang hi ani ve lo, mahse ka pawm dan chuan a theih anga tha in a nunga, a beihzawh rual loha thlemna nasa a tawk ani zawk. Mi nu tamtak te chuan an fate Pathian rawngbawl tura an thlah liam chuan an in ti thei hle ang, thil ropui tak ani bawk a, rawngbawltu te tum ber chu kawng hrang hranga chanchintha hrilh a mi te Pathian thu awih tir ani, ka fapa pawn ka tan chu chu min tih sak a ni. Kawng tam takah mi fel ni lo mah se a tana ka tawngtaina te hian Pathian ringtu tha takah min siam , Pathianinin kawng hrang hrangin kan nun hi a hmang thei a, mi fel leh tling a tehna pawh hi mihring kan in tehna ang hi chu anih ka ringlo. Ka fapa hi ka hmangaih a, a thih dan hi mi dang pawm theih chi nilo mahse, a nundan te leh a thih dante hian Pathian min hnaihtir a, Pathian chuan a thiltih avang hian lawman a pek ka ring tlat a ni.

APPENDIX - H

THE ONE THAT LOVES

(Mizo Version)

Ka pasal hlui leh kum sawmthum chuang ka thian lo ni tawh chu damdawi hmansual vangin a boral a. Damdawi a ti tawh thin tih chu ka hre tho a, mahse alo khawih leh tih ka hre miah lova. Kan inneih hma hian damdawi (heroine) a khawih nasa hle thina, mahse kan inngaihzawn hma kum engemawzatah khan a damdawi tih te chu nghei felin kan inngaihzawn chhung leh kan inneih tirh ah pawh damdawi chu a khawih miah loa. Mahse vawi khat chu a inti palha, chuta an damdawi chawh chu a addict ta tlat maia, kan inkar a tihchhiat dan te ka hrilha, counselling ah te a kal a mahse a hnu rei lo te ah chuan a ti leh zela. A counsellor te nen pawh kan inbia a kan tih theih ang tawk hi chu kan tia, mahse hna alo nei lo bawk nen hunawl a ngah luttuk te chu kan chhiatphah ani ber, tih tur a nei bawk silo. Hetianga ka buai chhoh lai vel hian fa pahnih kan nei ve tawh a, keiin sumdawnna engemaw ka enkawl ve a. Ka hnathawh laia ina lo awma ‘chhangchhe pa’ nih chu a phur viau a, mahse a damdawi ruih vanga khum atang pawha a thawh that peih miau loh avangin fate enkawl tlak chu anilo. A rui thei luttuk chu a intihpalhna na paawh chu a hre tak tak pawhin ka ring lo.

Hetianga kum engemaw chen kan awm hnu chuan aman insiam that tumna pawh a nei siloa ka hun tawn tawha ka thutluka siam harsa tih ber mai ka siam ta a, chu chu inthen a ni, mak a tiin a thinrim em ema, engemaw tal tih theih a neih leh neihloh min zawta keichuan kum tam tak inthlak danglam turin ka ngen tawha mahse a theilo ani tih ka hre tawha chuvang chuan keimah ka inngaihtuah ve a hun tawh thu in ka chhanga, ka hmangaih em vangin hlimlo leh inti lungawi lo reng renga hun hman ka duh tawh loh thu ka hrilha. Lungchhe tak chungin mi sawisel nuai nuai na karah kan inthen ta a. Ka rilru pawh a hah hlea chu mai bakah a damdawi tih chu an damdawi chawh pangai rui tawh lovin khawlai vela damdawi an zawrh ang hi a ti chho leh tan ta a, engkim hi a buai nuaih nuaih a ni ber. Kan fate hmu tur pawh hian a rawn kal lo foa, naupag ho pawh an rilru a na in keipawh ka rilru ana hle thin. Kawppui dang kan nei ve ve a, vanduaithlak deuh maiin a thiannu chu damdawi ti mi alo ni ve leh zela, an pahniha an han intawng chu thlipui natak ang mai niin ka hria.

An pahnih chuan damdawi tisa anlo ni bawk nen, bawihi pa pawh chuan damdawi chi hrang hrang a khawih belh ta nual maia.

Hetiang reng reng hian kum engemaw chhung chu kan awma, ka chunga a thinrim em em chang a awm a chutiang hunah pawh chuan thian erawh kan la ni reng tho. Ka ngaihtuah em em ani tih leh tanpui duh reng tih chu ka hrilh fo thina. Harsatna aneih te chu a zep tlat thina, nikhat chu ka bulah chuan engkim a in puanga, a nun dan hreawm a ti zia te min hrilha, chutiang min hrilh avang chuan atana pawi thei tur eng thil mah ka tih loh tur thu ka hrilha, amaherawhchu alo that chhuah leh theih nana tanpui ka duh thu ka hrilha. Hemi hunlai hian kei chuan pasal dang ka nei leh tawh a, ka pasal pawh chuan bawihi te pa puih chu tha alo ti ve bawka. Rei vak lo hi chu a'n tha ve leh mai thin a mahse drug addict chhungte chuan an hrethiam vek anga nghei leh nghei lo inkarah hian kan awm reng mai ani.

A thihni thleng khan atan hian ka beidawng ngai loa. Vanduai thlak takin ka thian tha ber pakhat chuan October thla khan min boralsana. Chuan Bawihi pa thiannu chuan min boral\san leha, amah nen pawh hian kan inkawm ve thoa, a thih hma thla phei kha chuan tanpui turin min mamawh hle niin ka hria. Ani pawh hi overdose thoin a thia, chumi a boral hnu chuan Bawihi pa chhungte chuan engawmaw tih a hun tiin ruahmanna an siama. Bawihi pa chuan a ngaihsak duhloa a kal bosan daiha, a thiannu thi chu a tuar ve viau niin ka hria. A rawn haw leh chu a chhungte chuan an ngaihsak duh loa. Ka pasal leh kei leh a thian pakhat nen chuan a centre awm theihna tur hmun kan zawn saka, thlasik khawvawh lai ani bawk si nen kar hnih khat tal a awm theihna tur kan duhpui ani ber.

Hetia kan buaipui lai zawng zawng hian an ngai pawimawh lo tih hre mah ila a chhungte chu a chanchin ka va hrilh ziaha, keipawh fa nei ve tho ka nihna ah an fapa chanchin chu hriaa, ei leh in tur neiin in lum ah a mu ani tih a hriat chuan a unau te pawh an mutui zawk ang tih ka rin vang ani. A tawp a tawpah chuan state pawnah rehab a awm a duh takzet ani tih chu a chhungte chu ka awih tir thei hrama. Rehab ah chuan ni 45 lai a awm a, hemi chhung hian tha takin a khat tawkin ka zuk be thina, ani pawh in felt akin min lo be bawk a. Kan inkarah thil tamtak awm tawh mah se kan la in hmangaih tawn em ema, thian tha ber kan la ni reng ani. Ka hmangaih reng avang khan ka thu tlukna siam tam tak te pawh kha a harsat phah viau reng a, hmangaih chung renga hetiang thil vanga inthen chu harsa tak ani.

A rawn haw chuan amah pawh chu a tha viau a, hlim tak leh hrisel taka han hmuh chu a thlamuan thlak takzet ani. mahse a rei lo hle thung. A harhfim chhung rei lo te ah chuan mi dang tam tak sawiselna karah harsatna tam tak a hmachhawn nghala, a bialnu a sun nen, in luah tur a zawn a ngai bawk, pawisa a nei bawk si lo. Hun reilo te chhung mah nise hun tha tak kan hmang ho hman a, chu erawh chu chatuana ka lawman ani ang.

In luahtur a zawn lai chuan a chhungte chuan kar hnihn khat vel an bula chen rih an rem tih saka, chumi lai chuan an in ah a boral ta ani. A thih hma kar chuan a mize hlui – a fate hmuh atum huna rawn kal leh siloh ti ang te kha a chin leh avangin ka ngaih a tha zan lo deuha. Damdawi a khawih apiang hi chuan min hnaih duh ngai lova, a chhan chu ka hria ang tih a hlauh thin vang ani. Ni hnih khat vel chu min hlat hle maia, a hnua ka hriat leh danin hetih hunlai vel hian lirtheiin alo chesuala, BP (bloodpressure) hniam avangin damdawiin ah alo awma. Chumi hnu reilo teah chuan an inah an mahni thuthlengah a boral a ni.

Vanneihthlak takin kan nupa leh ka fate chu a vuina ah kan tel ve theia, Doctor-in lungphu chawl (heart attack) emaw thisen khal (blood clot) vang a nih a rin thu min hrilha. Thil thleng dang tam tak pawh min hrilh loh avangin chu aia chiang zawk chu an hriat ka ring. Tha taka kan inbiak chhung chu a reilo hle, reilo teah chuan a thih avanga enge maw hamthatna dawn theih ang chi a chuan kan buai ta nghala, a chhungte chuan a fate ai chuan chan phu zawk in an in hre tlata. Chumi chungchangah chuan kan in ti thiam vaklo nghe nghe a, an thinrim hrikthlak nan ber min hmang ta a. Keimah avanga damdawi ti anih thu min hrilha, a vuina vela sum sen ral chungchang an sawisel avangin keiman a lungphun chu ka inhuam thu ka hrilha. Tawngkam chhe tinrengia min puhna leh demna in min lo chhanga. Kan lusun rilru nat laia an tute pawh an ngaihtuah reng reng lo hi chu ka rilru ana takzet. Lusun hi chu ana ema ka lainatin rilru puthmang mak tak tak te pawh an nei hi ka hrethiama, mahse rinphak baka an fapa hmangaihtu kei leh ka fate chungah chuan chutiang lainatna rilru chu an pu ve reng reng lo

Engtik lai maha a tana ka beidawng ngailo kha ka in chhirlova, ni sawmli leh panga a inenkawl hnua a tlukna ngaia a tluk leh avang khan ka thin a rim bawk heklo. In lamah hriatchhuahna tur thlemna alo awm ve bawk nen, rei tak damdawi lo ti tawh tan chutiang hun chhung leka nghei fel hmaka dam hlen theih chu thil awihawm loh

tak ani zawk. Mi tha tak anihna hi ka theihnghilh ngai lo anga, a chhungten eng ang pawhin minlo sawi mahse hlim taka kum tam tak kan hman dun tawh te chu min laksak thei chuanglo. Ka ngai ngawih ngawiha, ka chan tak avanga ka tawrna hi a reh tawh lo ang. Nitin hian a reh tial tial anga nakinah chuan kan in hmu leh ang tih hi ka beiseina ani.

APPENDIX – I

Father of One
(Mizo Version)

Kum sawmhnih dawn sawrkar hna thawk tawhin ka nupui nen hlim takin kan innei a, kan inneih hnu kum hnih velah malsawmna dawngin fanu duhawm tak kan nei a, ani hi kan fa neih chhun a ni.

Kan hna in a zir loh avangin thingtlang hmun hrang hrangah ka insawn kual ngun em em a, mahse kan fanu chu sikul kal rual te alo nih ve takah chuan kan nu ne chuan remruatna siamin Aizawlah inluah in kan nu chuan kan fanu a awmpui ta a ni.

Hun alo vei chuan keipawh chu khawpui hnaih deuh ah te chuan min post ve ta a, chutih lai chuan Aizawl ah mahni in leh lo din in kan in beng bel ve tan ta a, ka post chu Aizawl atanga hla lo te anih avang chuan chawlh kar tawp hian kan in lamah chuan ka haw ve mai thin a. Chutia kum hnih vel kan han awm hnu chuan keipawh chu Aizawl ah chuan min dah ve ta hlauh mai a.

Hreawm lutuk leh rual awh loh na tur tawk ka thawkchhuak a, ka nupui leh ka fanu te pawh nuamsa takin ka siam ve thei a, kan chhungkua chu kan hlim hle thin a. Kan nu nen hian fa dang neih leh te pawh kan han tum thin a mahse a hriselna lamah harsatna a neih avangin fa chu pakhat chauh kan nei thei a, mahse kan fanu chuan min duat in, min ngaihsak em em a, kan pathum chuan kan hlim ve hle thin a ni.

Chhungkaw inpawh tak mai kan ni a, engkim mai hi kan titi na ah hian kan sawi vek thin a, kan pathum chauh ni mah ila chaw ei dawhkan kan kil te chuan kan nui nasa ve hle thin. Kan fanu Lisa-i chuan fiamthu hian pasal nei lovin kan nupa chuan min enkawl reng tur thu te leh kan bula a awm reng duh thu te chu a sawi thin a. Kan nupa chuan kan fanu puitlin hun tur chu kan nghakhlel in kan sawi dun nasa thin hle ani. Alo len hunah khawi sikul ah nge kan kal tir anga, a lehkha zir naah pawh kan theih ang tawk a kan tawiawm zel dan tur te kan suangtuah thin a. Mathematics te a thiam in Lisa-i chuan engineer a nih chak thu te sawiin kan nupa chuan a len hunah a nih chak tak a nih theih na turin kan fuih nasa hle a.

Lisa-i chu a nu nena in pawm deuh chawt anih avangin a naupan tet lai chuan thian pawh a kawm tam lo hle thin, thiante ina chaw ei khawm nikhua te hian kan kan

bulah a awm deuh chawt mai thin a ni. Kan nupa chuan Lisa-i chu Aizawl a sikul kal zo chu tha kan ti dun a, ama duh thlan na ngeiin pawl sang zawk a zir a college te a kal theih ve hunah chuan phai lamah la dah turin ruahmanna te chu kan siam a. Ani pawh chuan kan rawtna chu tha a ti hle a. Kum te alo vei a, a rawn tlirawl chhoh chuan sikul tharah pawl riat zir turin a lut ta a. Sikul an tan tirh chuan amah pawh amah pawh a inti nula ve deuh tawha sikul a thlah bik nih te chu a zak a, kan nupa chuan kan titi na ah pawh kan sawi chhuak fo a, kan fanu neihchhun chuan min thansan chak lutuk tur chu kan ngaihtuah in kan khua te a har ru viau zel a.

Kohhran lamah pawh Lisa-i chu inhmang tak mai a ni a, kan veng chhunga a thiante chu biakin lam atanga a hriat te an ni hlawm a, thian ngah lutuk mi a ni lo chung in a thiante chu naupang fel tak tak an ni hlawm a. Sikul chawlh leh chawlh kar tawp te hian kan inah te rawn kal khawm in filmte an en ho thin a, kan inah te chuan an rawn infiam thin a ni.

Kum sawmpanga a rawn tlin chuan kan fanu chuan a birthday present atan mobile phone min dil a, an sikul ami a thian te pawh in an neih thu te leh a awh ve thu te min hrilh a, kan nupa chu in rawnin a thiante zinga rualawt bik a siam chu tha in kan hre lova kan remtih sak ta a. A kum rualpui ah pawh a rilru put hmangah a puitling bik em em a, pawl kaw zirlai alo ni ve ta reng mai a. Ka fanu hian a tet lai atang tawhin thil min dil hian phalloh ka nei ngai meuh lova, kan nupa pawh kan thu a inhmuh loh phah fo thin. Kan nu hian kei ai chuan a khuahkhirh thiam zawk ani.

Krismas hi kan chhungkaw chawlh bik riau ah kan ngai a, kan thenrual hnai leh chhungte sawmin an inah te tlawh chhuak in hun kan hmang tlangpui a. Kan chhungkua hian a hrangin krismas kan la hmang ngai miah lova, Lisa-i pawh chuan chu chu hre rengin khami kum khan a thian te nen kumthar hman kan phal leh phal loh min zawt a. Sikula athiante chuan kumthar zanah hman ho ve an tum thu te leh ar te kang a ina film te en pah a awm khawm an tum tih min hrilh a, tel ve ngei a duh nachhan chu kum tin mai inah a ngai hlirin kan hmang chu hmun danga hman ve a chak tawh thu te leh krismas chu kan chhungkaw chawlh deuh a kan ngaih avanga kan bula awm a, kumthar a thiante nen a hman a chak thu te chu sawia. A nu nen chuan kan in rawn a, thil awmlo luttuk a nih loa a, thiante ina hmang ho tur an nih tho te chuan kal ve se ti in thuthlukna chu kan siam fel ta a. Kan phalsak tih a hriat chuan

a hlim hle mai, nui var var chung hian puitling takin a awm anga ngaihtuah awmin a awm loh tur thu min hrilh a.

Kumhlui thlah zan alo thlen chuan kan nupa chuan kan thiante ina chaw ei tura kan kal pahin Lisa-i chu a thiante inah chuan kan thlah kual nghal a. Kan mut hnu chuan zanlai tak ah hian kan phone chu a rawn ri a, ka han chhang chu Lisa-i chuan kumthar chibai min rawn buk alo ni a. An kumthar hman dan chu nuam a tih thu leh a tuk zingah a thiannu pa chuan kan inah a rawn thlah dawn avangin kan lam a ngaih dawn loh thu te min rawn hrilh pah bawk a. A vawikhat riah chhuahna anih avangin kan in te chu reh ta riau in ka hria a, kan nupa chuan kan khua a har em em a, alo haw hlan kan nghak hlel hle a ni.

A tukah chuan Lisa-i chu a thiannu pa chuan chhun thingpui in hma deuh hian a rawn thlah a, rawn haw tura a sawi hun vel chu a ni a mahse han hmuh chu a nuam hle mai. Kumthar ruai theh ni te anih avangin kan nu chuan Lisa-i chu intifai a insiam turin a a tia, a va inthlak sawk sawk a, kan chhungkua chuan ruaitheh tur chuan kan in buatsaih ta a. Chutih lai chuan a hma zana a thiante nen bawk chuan kawn leh kawngdung chei vel en tura chhuah kan phal leh phal loh min dil leh ta a. A in tiam ang thlap a fel tak leh puitling taka min dil avang chuan a nu nen chuan kan phal leh ta mai a, zan dar kaw hmaa in lo thlen leh ngei a ngaih thu kan hrilh bawk a.

Ruai theh zawh chuan inah kan haw a, ani pawh chu a inseam a. A thiante inah chuan thlah a ngaih leh ngaih loh chu ka zawt a, ani chuan an rawn lam kual mai tur thu chu min hrilh a, chumi hnu reilote ah chuan an kal ta a. Zan dar 8:30 vel a ni tawh a, lo nghah chhuah ngei kan tum a, zan dar 9:15 vel chuan in a la rawn thlen loh avang chuan kan nu chuan a call ta a. Lisa-i chuan motor kawng a tawt thu leh an la tan thu alo hrilh a, anlo haw mek avangin lo thleng vat turah kan ngai a kanlo nghak ta a. Ani pawh chu minute 20 hnu velah chuan a rawn thleng ve ta mai a, a chauh hmel in amah chu a nguai riau a. Damloh leh nawmloh na a neih leh neih loh kan zawh chuan motor a ruih thu in min chhang mai a. A tet te atang tawh in motor chuan harsat mi anih vangin ngaiah kan nei mai a, a roomah mu hahdam tura kan tih hnu chuan kan nu chuan a in tur theitui a siam sak a, bathroom a a in phih fai vel lai chuan a khum bul dawhkan ah chuan a va hun sak a. Kan in mangtha fel hnu chuan kan pindan lam pan chuan mu turin kan phei ve ta a, zan dar 10:30 vel a ni.

A tukah chuan zing dar 6:30 velah kan nu chu tho in thingpui lum tur chuan a phei ta a, tuktin a a tih thin dan bawk in zingah thingpui a lum fel hnu ah hian kan pa fa in min rawn kaitho thin a. Zing dar 7 velah chuan Lisa-i room pindan kawngka chu kan nu chuan hawng in kaihthawh a tum thawm chu ka hre ta a. Zing thawh harsat lo tak anih avangin zingah hian a mu rei ngai meuh lova. Chutia kan nu in a'n kaihthawh dawn lai chuan kan nu rawn au thawm hi ka hre ta a, rang takin ka tho chhuak a kan room dawt chiah a Lisa-i room ah chuan ka tlan lut ve nghal a. Enge thil awmzia ti a ka'n zawh chuan kan nu chuan a kaih thawh theih loh thu chu kan fanu khum a thu a pawm chung chuan minlo hrlh ta mai a. Ka ngaihtuah let leh hian mumang chhia ang mai hian ka hre ruai a, engmah kha chiang takin ka hre chhuak thei ta tlat lo mai.

Kan nu chu chelh in Lisa-i hming chu kan ko dun ta a, mahse min chhang ta si lo. Thi tura ngaihna kha ka rilru ah a lang lo hrim hrim a, a kut vawt vek tawh vuan chung pawh khan a thi tih chu rin harsa tak a ni. Chutia kan buai nuaih nuiah lai chuan kan thawm chu thenawm ten an lo hria a kan kawngka ah chuan rawn tlan khawm in kan la hawn loh avang chuan min lo nghak a, kei chu kawngka hawng tur chuan ka phei ta a. Kawgka ka hawn hun chuan enge ka hrilh dawn tih pawh ka hre thiam thei mai lo, enge thil thleng kha ka hriat thiam miau loh avangin.

Kawngka ka hawn chuan thenawm te chu rang takin an rawn lut a, zawhna chitin reng min zawt in eng thil nge thleng a, engtia tleng nge a nih tih te, engtik a thleng nge tih te chu minlo zawt hlawm a, an zawhna te chu keimah pawn ka zawhna ve tho a ni.

Khawtlang leh khohhran hruaitute kan in an lo thlena kan thenrual tha te an rawn thlen khawm hnu chuan Lisa-i chu khumah an zalh tawh a, kan in te chu an singsa ta vek a. Enge thil awmzia kan hriat chian loh avang chuan police te pawh chu koh an ni a. Thil kal hmang reng a nih avang leh nat lawkna nei miah lova boral thut an awm chuan Police tel ngei kha tha a min rawn vang a ni. Kan han thu khawm a, kan fanu a tet laia life insurance kan tih sak kha thuneitu te an lo kal a, an ni chuan a insurance kan lak theih na tur chuan hospital ah post-mortem report te an mamawh tur thu min rawn hrilh ta a. Ka unau pa chuan chu chu thil finthlak tak a nih mai bakah a chhan hre miah lova kan thlah liam mai tur khan nakin zelah kan hreawm phah a hlauh avangin khawtlang hruaitu te thurawn angin post – mortem tur chuan lehkha chu kan siam fel ta a.

Post-mortem an zawh fel meuh chuan chhun alo ni hnai tawh mai a, Young Miizo Association te dan kal lai angin zing dar 9 hma a boral an awm chuan a ni la la a vui tur an nih avangin khami ni tho khan kan vui liam taa. A ruang chu inah pawh a awm mumal hman loh avangin kan khawtlang hruaitu ten min duhsak a tlai dar 3 a vui chu min phalsak ta a. A thih chhan kan la hriat mumal loh avang chuan lungphuchawl tiin an ziak ta a.

Chumi atanga ni thum hnu ah chuan ka unau pa chuan min rawn phone a, ani chuan damdawiina a awm thu leh post-mortem report te a ngaihven tur thu chu min rawn hrilh a, mahse kum bul lam te a ni a mi an la office tha lutuk lo bawk nen chuan rin ai tak chuan a rei ta a. Kan chhiat tawh avang chuan kan nupa chu khawiah mah chuak thei kan nih loh bakah kan tuar na hle mai a, ka unaupa chuan min lo bengvar sak ta a ni.

Kan in alo thlen chuan kan choka dawhkan ah chuan thu tur chuan min ti a, lehkha chu a rawn phawrh a, han hawn mai chu ha hreh angreng khawp mai – ka fanu ka channa chhan kha eng vang tak nge lo ni a, thil pumpelh theih reng ni si chu kan lo ngaihthah vanga tiang dinhlun thleng hi kan ni mai em tih te chuan ka rilru a luah khat hneh hle mai a. Chutiang alo ni anih vaih chuan keimah leh keimah pawh in ngaihdam harsa ka tih tur zia te chu ka rilru chuan a thlir lawk vek a ni. Zawhna tamtak chhanna ka duh a, mahse a chhanna chu ka hmachhawn ngam chiah em tih erawh chu ka chiang lo hle.

Ka unaupa chuan lehkha chu a han hawng a, kan nu chuan a han la a. Lehkha a en pah chuan a mittui chu a tla ta zawih zawih mai a, a kut te chu khur in *“a ni theilo”* hi a rawn ti a, chu veleh chuan lehkha chu ka han en ve ta a, chiang em em mai hian alo in ziak kalh mai chu ka hmu ta, damdawi hmansual vanga boral ta tih in alo in thai kulh mai. Ka han chhiar chian leh deuh chuan khuh damdawi leh grape tui in pawlh avanga thi chu a ni tih a nit a.

Chu ai mah a kan nupa tana thil mak chu kan fanu Lisa-i khan khatiang a ti kha a ni. A thih chhan kan han hria chu dawt min hrilh ang tlat a ngaih na kha ka nei nasa hle a, kan baihvai in sawi tur engmah kan hre lova, mak kan ti em em ringawt mai a.

Ka unaupa chuan kan vuini a a thih chhanah khan lungphu chawl ang khan a inziak a, post-mortem in thil dang a rawn hmuchhuak leh bawk si, engkim a thleng tur chu a thleng fel vek tawh a keini chu insawi fiah kan ngaih loh thu chuan min hnem a. Kan fanu thih chhan dik tak chu tumah dang hrilh lo tur chuan kan in tit a hlawm a. A thih na chhan kan hriat tak a mi hnenah kan sawi avang khan engmah a danglam thei dawn chuang lo tih chu kan in nghah na a ni a, a kal tawh a, a thih chhan diktak avanga mi hmuhsit leh sawi kai a ni tur chu kan phal theih ngang loh avangin kan chhungkua bak chuan tuman hre lo se tih chu kan duh dan a ni.

Tuna ka thlir let hian kan chhungkua thil paltlang zozai te kha, ka thuthlukna, a thih chhan diktak kan tarlang ta lo kha ka la inchhir chuang lova, in lam let duhna pawh ka nei chuang lo, a chhan chu ka fanu kha addict a ni loh vang a ni. Kum 16 mi lek a ni a, an kum rualpui naupang ho thil tih a hriat chak avangin alo ti ve ngawt mai kha a vanduai pui ta mai a ni , engmah chutiang bak chu a awm si lo. Chuvangin mihring a nih laia a zahawmna te kha ka humhim sak ah ka in ngai.

Kan fanu kha kan hmangaih em em a, vawiin ni thleng hian kan la ngihtuah thin, khatiang kha lo thleng ta lo se chuan thil hi a danglam nasa awm si a. Mahse kan fannu Lisa-i kan sunna hian kan nupa inkar chu a aia nasa zawkin min phuar ngheta, amah pawn hlim taka kan awm hi min duhsak ngei in kan ring tlat.

Kan fanu chu a awm tawh lo pawh a ni maithei, mahse amah kan hriatreng na te hi a la pung zel a. Kan ngai em em a, chu chu kan zinga kan awmtir reng theih dan a ni.

A dam chhung kha rei tak ni turin duh mah ila a tawi em em a, mahse tunah chuan hmun nuam zawkah a awm a, min lo thlir reng a, kan hreawm leh hlimlo lai te min hmuh hi kan duh lo a ni.

Kan theih ang zawng zawngin kan hum a, naupang tha tak ah alo chhuak a, mahse nu leh pa tamtak te chuan kan fate chinchang hi kan hrelo thei hle a, thil tih danglam kan chak a kan duh rual rual in, a nu leh pa te kan nih na angin, a zahawmna kan hum him sak hi kan mawhphurhna kan hlen tur chu ani.

APPENDIX - J

Brothers
(Mizo Version)

Kan unau hi pali ni in a naupang ber ka ni a, u mipa pakhat ka nei a, ka nu leh pa ten min la dam pui ve ve in ka u hmeichhia te pahnih chuan pasal an nei tawh a, kei chiah hi tunah chuan ka nu leh pa te bula awm ka ni.

Kan tet lai atang tawh in ka u Andrew nen hian kan in hnaih bik em em a, kan inkar ah kum thum tla in, a kalna apiangah ka zui ve thin a, amah pawn min awm hnem em em a. Ka lakah dawhthei in min hum nasa thin hle a, ka tan chuan entawn tlak tak ni in, ka hriat theih tirh atang ka ngaisang em em thin.

Andrew-a chu mi ngilnei tak leh mi ngainat hlawh tak mai a ni a, thiante ngaina mi leh mi thilphal tak a ni bawk. Hun a lo rei deuh chuan a thiante pawh ka thiante an lo ni chho ve zel a, kan in zui nasa thin hle. Mi talent nei tha tak leh themthiam tak ni in, music a ngaina em em thin a, eng music instrument pawh hi thiam takin a tum thei zel a, guitar, drums leh keyboard tum te chu a hnehsawh hle in min zirtir ve thin a. Ka chungah dawhthei takin leh a thiante chungah pawh ngaihdamna ngah a ni a, kan thian ho zingah pawh khan a hotu leh neitu nih a thiam em em thin.

Music a thiam ang bawkin thian siam a thiam a, chu chu a mizia ah pawh ka ngaihsan pawl tak a ni. Kei ve thung chu zakzum leh ngawichawi tak ka ni thin. Kan inkawm ho na ah te pawh kil khatah an titi te lo ngaithla in an zinga awm nuam ka ti em em thin a, ka u chu ngaisang takin an bulah chuan ka lo tap ve a. Ka u mizia a ka hriat reng thin chu, an sirah lo zui in lo awm ve mai mai thin mah ila mal a awm ang a ka in ngaih loh nan hian min ngaihsak em em thin a ni.

Kan rawn len deuh hnu ah pawh ka nu leh pa ten sikul hmunkhat a kal chu a remchan mai bakah tha min tih sak avangin sikul khat ah te kan lut a, ka tan chuan a nawm phah mai ni lovin ka thlawp zawng tak mai alo ni bawk nen, ka u nen a sikul hmunkhat a kan kal avang chuan keipawn sikul kal te kha nuam ka tih phah hle thin.

Ka nu leh pa te chu sakhaw mi tak ni in kan naupan lai atang inkhawm te an ngai pawimawh em em thin a, inkhawm pawh kan thulh ngai meuh lo. Kan unau

hmeichhia te chuan an than lend an chanchin hran an neih laiin kei leh ka u Andrew-a pawh chuan kan nei ve bawk.

Room khat intawm in kan in bel chawt hi a ni deuh ber mai, engkim mai hi kan ti dun thin. Kan han titi ve chang te chuan music lam te, kan len huna kan hun hman chhoh zel dan tur te leh kan hma hun lo awm tur te chu kan unau chuan kan sawi ve thin nasa hle a.

Zirna lam ni se ka homework ah te min pui in, guitar perh te min zirtir thin a, ka thanlen na kawng tam zawk a ka thil hriat leh thiam te hi ka u Andrew-a khan min zirtir chhuah vek ni in, nun awmzia leh thih thlengin amah atang hian ka zir chhuak nasa em em a ni.

Mi lehkha thiam thei tak ni chung khan zirna lam ah khan a rilru a pe lutuk lem lo khawp mai a, mahse kan kum ngaihtuah khan thil awmlo pawh a ni lem lo. Middle school kan kal laiin ka u chuan high school a rap ve tan a, sikul kha a hmun awm chak na ber chu a ni lo ve khawp mai. Ka la hriat reng chu ni khat sikul a kan awm lai chuan kan chhun chawlh laiin min rawn ko a, ka ipte la turin min ti a, kei lah chuan engmah zawt buai lem lovin ka ipte chu ka la ve ta mai a. Sikul hnung lampang a hungna bang sang tak mai chu min lawn liam pui a, chumi tum chuan kan thian dang te nen kan ni nghe nghe, chu chu ka sikul tlanbo hmasak ber a ni. Chumi tum chuan inkhel en turin field ah kan kal a, inkhelh zawh ah chuan kan unau chuan kan haw a, khua chu a thim titih tawh a. In kan thlen chuan ka nu leh pa te hmelah chuan an lungawi lo tih chu ka hmu nghal mai a, kan principal chuan alo phone a kan sikul tlanbo thu chu alo hrilh tawh ni ngei tur a ni. Kan sitting room pindan kil ah chuan ngawi reng hian ka ding a, ka nu leh pa te chuan kan ti leh a nih vaih chuan min hrem ngei tawh tur thu minlo hrilh a, ka u ka va en chuan ani chuan hlau hmel pu miah lo hian alo nui var var mai a, ka pa chuan thinrim tak mai in alo en ve bawk a. Ka u kha ka ngaihsan phah in, huaisen ka ti em em mai a, min thlamuan in ani kha awm lo ta se la chuan ka tap hial in ka ring.

Nu leh pa tamtak fapa pahnih harhvang ve tak nei te ang thovin ka nu leh pa te chu an strict in min thunun nasa hle thin a. Kum sawmpali ka nih in ka u Andrew-a chu kum sawmpasarih mi a ni tawh a, high school ah kan kal v eve tawh a ni. Khatih hun lai khan band kha kan din a, kan unau leh kan thian thenkhat te nen. Chawlh kar tawp apiangin kan inah inhmu khawm in hla te kan zir ho ve thin a, chutia kan in

hmuh khawm a kan in kawm hlim na lamah chuan zialzuk te kha chu ngaiah kan han nei chho mai a. Kum khat vel a rawn vei kha chuan kan unau chuan kan nu leh pa te hriat loh chuan zial zuk ruk chu kan ti thang tawh hle a, kan thian te zawng zawng pawn an zuk ve avang chuan pawi tih na kan nei lo bawk.

Ni khat chu chutiang a kan in hmuhkhawm na ah chuan kan thianpa pakhat chuan a hmelhriat pakhat in Ganja a pek thu a sawi a, keini lah chuan pawi tih lam aim ah chuan kan lo phur in kan lo lawm em em mai a. Tih ve chhin kan chak ta vek mai a, chumi ni chuan kan zu tlang ta a, kan hlim in pawi kan ti lo hle bawk nen, tih leh duh na rilru kan nei ta hlawm a. Ka u Andrew-a chuan kan thianpa hnenah chuan kan hla zir ho leh hunah pawh lo keng leh turin a chah ta nghal a. Chuta tang chuan kan in hmuhkhawm apiangin tel tur a ngaihna kan nei lian ta hle mai a, kan hla zirna hun a kan hman thin te chu ganja zuk nan kan hmang tam ta zawk a, ka nu leh pa te erawh chuan engmah min ringhlel lova kan zalen em em a ni.

Hun a kal zel a chutia kan tih chhung chu kum a vei ta mai a, nikhat chu kan thianpa pakhat chuan kan in hmuhkhawm ni tur chuan a rawn thleng tlai khawp mai a. Ka la hriat reng chu khua a nuamlo hle a khami ni khan, kawngka chu a rawn kik a kan va hawn chuan alo ding a, a rawn phur in a thawm te pawh chu a rawn ring lut viau mai a. A ipte rawn ah luh chu a han hawng a zu um a rawn phawrh pah chuan a rawn lei ani tih te chu a sawi ta a. Keini pawh chuan phur tak leh nghakhleh tak chuan kan hawng a no ah chuan kan han thli ta a, chumi chu kan unau a zu kan in hmasak ber tum a ni nghe nghe.

Tleirawl thaza rual lek kan ni nen khatiang hun lai kha chuan a pawina tur engmah kha kan la ngaihtuah thiam chiah lova. Kan thian ho zingah pawh khan han in khap leh ti lo tura in fuih kha a awm ngai chuang lova. Thian ten an tih kha chu tih ve theih zel kha kan duh a, a ti theilo bik nih kha chuan dawihzep ta riau a in ngaihna kha a lian awl em em mai a. Rilru chuan kan upa anga kan thansan leh mai tur thil anga ngaihna kha a lo awm ve vat bawk nen, thian ten en chuan kan ti ho ta dial dial a.

Hun alo rei leh ta deuh a, zu um khat kan in atang khan kan lo in hnem ta tial tial a, khami kum kha alo zawh dawn meuh chuan a hma a kan zial zuk te, kan ganja zuk te ang bawk chuan zu in pawh kha ngaiah kan lo neih chho ve leh ta mai a.

Tichuan kum al oral dawn a sikul te chu kan lo chawl dawn hnai ta a, kum danga kan tih thin dan bawk in kumtawp sikul chawlh dawn a scholarship kan dawn thin chu alo hun leh ta dawn der mai a. Scholarship la tur a kan principal office pawn a allotment card nen kan lo in tlar thap mai a, rei fe kan nghah hnu chuan kan hun alo thleng ve ta. Pawisa chu kan han dawng a, kan kut ah kan han hum ve ran a, kei, ka u leh kan thiante nen chuan lawm ngawt mai kha kan rilru ah a lian tlang bawk aniang chu, kan tih tur te kan han rel ho ta a.

Kan unau chuan inah kan haw ta a, kan nu leh pa te bulah chuan kan thian hovin chaw kan ei khawm dawn thu kan hrilh zawh ah chuan kan inseam ta sawk sawk a kan kal leh ta nghal a. Kan nu leh pa te hian kan unau a kan kal anih hi chuan an ngaih a tha em em thin a pawi khawih turah min ngaih loh avang hian an lo phal ve leh mai thin bawk a.

Kan thainpa te in kan va thleng a, thil tha deuh mai an neih thu min lo hrilh a, enge a nih tih hre chak tak mai chuan kan han zawt ta vat a. Chutah a ipte atang chuan glass but te tak te hi a rawn phawrh chhuak ta a, ka'n en chian chuan a chhungah chuan powder tam lutuk lo hi alo awm a. Ka u Andrew-a chu ka en a, ani chuan mak ti miah lo hian enge a nih tih hre sa ni awm tak hian alo en a, mak ka tih em avang chuan enge a nih chu ka zawt ta a.Ani chuan Heroin anih thu chu awlsam tak hian minlo hrilh ve mai a. Drugs an hman luar em em a ni tih chu ka lo hre tawh thin a mahse chu bak chu engmah ka la hre ngai reng reng lo. Engtin nge a thawh a, engtia ruih tur nge tih chu ka hriat ngai loh thil a nih avang chuan hriat chakna in ka lo khat ta a.

Ka han zawh chuan *"kan chase dawn"* an lo ti mai a, hrelo nih hreh deuh chung chuan ka aw liam vet a mai a, ka u chuan ka hlauthawng deuh tih chu a hria ni ngei tur a ni, chutih veleh chuan ani chuan inchiu a ngai lo ania a rawn ti vat a ka thawveng ta deuh huai a. Dawhkan chu kan thut bial a, an han inpuahchah ta a, tichuan kan han tit a den den a. kan zawh hnu chuan a ruih dan chu danglam ta riau hian ka hria a, zu in leh ganja ruih ai daih chuan a zangkhai ani tih ka hriat thiam hnu chuan ka tan chuan rilru siam a awl ta hle mai. Tih leh ka duh ngei dawn tih chuan ka rilru ka sawh nghet ta a.

Chumi zan a kan haw chuan ka u Andrew-a nen chuan kan thil tih te chu kan sawi dun a, kan damdawi hman leh a mi nghawng dan nawm zia bak chu thudang kan

sawi thei tar eng reng lo, kan vawikhat tih na ni mah se a tawpna tur a ni lo tih chu kan chiang duh khawp mai, tih leh ngei chu kan tum ta a.

Chuta tang chuan kan unau chuan kan pawisa neih leh khawl ang ang te chuan heroin chu kan lei ta zel a, mahse a man a to viau si a. Kan nu leh pa te chuan engmah min rinhlelh loh avang chuan kan tan chuan pawisa han dil mai te chu a la awlsam khawp a. Chutiang a thla hnih vel kan han *chase* hnu chuan bansan har chu kan tit a khawp mai, a damdawi chu kan ngai in a ngawlkan vei chu a ni der mai. Kan chase chuan a damdawi ruih chhung alo rei loh zawk mai bakah a thawk har a, a man a to bawk si nen, ka u chuan a thianpa pakhat inchiu thin a awm thu chu min hrilh ta a. Hriau ka hlauh thin zia chu a la theihnghilh lova, min thlamuan in ka u chuan zunthlum inchiu na thin hriau sin te an hman thin thu te min hrilh a keipawh chuan ka duh vet a mai a.

Ka u chuan a thiante pawn an tih tawh lai a hmuh tawh thu leh kan ti ve chhin anga kan thiam mai tur thu min hrilh chuan pawi ka tit a lova, a tukah chuan a thianpa te inah chuan kan kal dun ta a. Ani chuan inchiu dan chu min zirtir ta a, ka u chuan hriau sin tak mai chuan amah leh amah chu a han inchiu ta a, mak tak main a vawikhatna mah ni se a chiu dik ve mai a. Ka u chu ka nunna hial nen pawh a ka rin ngam anih avang chuan min chiu dawn pawh chuan hlauhna engmah keimah ah ka nei lova, min chiu hmasak na ber tum ni mah se a tawpna ber chu a ni hauh lo.

Kan inchiu tan atang chuan kum khat chu alo vei ve leh ta mai a, kan nu leh pa te chuan anlo hrethiam tan ta a. Inah kan awm ngai mang lova, kan hla zir te chu kan chawlhsan tawh bawk nen. Kan thian kawm thin te chu a lang a pau in damdawi hmang mi an ni tih chu khawtlang hriat ah alo darh tawh si nen, kan nu leh pa te tan chuan hai der rual a ni tawh lo.

Kan thian kawm thin te zing ami pahnih chu addict centre ah te an awm a, a la lut ve lo te pawh chu damdawi ti ve tho leh zu ngawl vei ah te an chhuak ve ta bawk a. Kan kum te a la naupang lutuk ve bawk nachungin kan thian ho chu ruihtheihthil ah kan buai nasa hlawm em em ta a. Zah lam ai mah chuan intihtheih nan te khan kan la hmang a, rui chung a khawlai kan len te khan nuam kan ti zawk in, kan hlim phah ve viau thin a.

Kan nu leh pa te laka phat theih loh khawp khan damdawi leh zu te chu kan lo khawih nasa vet a a, kan ruihtheihthil khawih ah khan a ngawl kan vei nasa tawh khawp mai, nghei tum pawh kha ni ila kan harsat tlang viau tawh a. Engmah tih theih a awm tawh si lo. Kan inchhung chu inhauh na leh in sual na ah alo chang a, ka u Andrew-a nen chuan kan in tan dun em em tho mai. Kan chhung te tan chuan engkim danglam vek mah sela keini tan chuan a la ngai reng tho a, kan in duhsak na leh kan in tan n ate chu a la ngai reng avang in.

Chutiang chuan thla engemaw chen kan hman ral hnu chuan kan nu leh pa te chuan ruahman na an lo siam ta a. Thuthlukna fel tak an siam anih loh chuan keini unau chu thunun theih loh kan ni mai dawn tih chu chiang takin an hmu tlang a. Inchhung bungrua tha deuh kan hmuh an gang te chu hralh mai kan pawisa lova, engkim mai pawisa a kan chantir theih tur ang chi kha chu kan ru chhuak mai zel a. Chutih hun lai chuan heroin man a sang chho zel si nen, ka damdawi ngaihna chuan inchiu leh hriau ka hlauh thin na te chu rawn luahlan in, damdawi tlawm zawk leh hmuh awlsam zawk te chu kan dap tan ta a, ruih theih tawh phawt chu kan hmang chho ta vek mai a. Ka pa beidawng chuan in lama min thunun theih tak miau loh avang chuan addict centre a min dah chu a rel ta a, mahse hmun hrang a min dah anih loh chuan kan thatpui loh an hlauh avang in addict centre hrang ve ve ah ka u Andrew-a nen chuan min dah lut ta a.

Ka u Andrew-a chu damdawi ngai te enkawlna hmun damdawiin ah chuan an dah lut ta a, kei chu kohhran enkawl centre ah min dah ve bawk a. Centre ah chuan kum khat dawn ka awm hnu chuan ka u erawh chu thla thum course chauh a ngaih avang chuan ka chhuah hma chuan a chhuak fel a, ka centre awmna ah te pawh chuan min rawn tlawh thin a. A in enkawl hnu chuan amah pawh tha chho viau in, kei pawh chuan that duhna rilru te pu in ka awm tluan ta a.

Ka chhuah hnu chuan ka u nen chuan a ngai ang bawkin kan in ngai in kan inkawm ngeih em em a. Kum hnih dawn lai chu ruihtheihthil engmah khawih lovin kan awm a, amaherawh chu ni khat chu kan thianpa pakhat nupui neih na ah chuan kan kal dun ta a.

Chumi zan chuan kan thian hlui ten en chuan inhmu leh in inneihna ah chuan chaw kan ei nghal a, kan thu khawm a kan titi hlawm a, kan han inkawm hlim chuan nuam kan ti tlang viau in kan phur tlang hle a. Kan thian ho chuan zu te in in kan rui

hlawm viau a, chutih lai chuan pakhat chuan heroin chu bur te hian dawhkan ah hian a rawn chhawp ta a, in chiu na tur syringe ten en chuan. Ka han en chuan ka damdawi tih thin lai a a ruih nawm thin zia te leh ka taksa leh rilru a danglamna a rawn thlen thin zawng zawng te chu ka hrechhuak leh ta a, tichuan syringe chu awlsam tak chuan ka ban ve leh ta mai a.

Kar lovah chuan damdawi chu ka hmang leh ta mai a. Kan nu leh pa te lakah chuan zep ngaiah pawh kan ngai tawh lova, kan inchhungah chuan inhauh leh insual in bul kan tan tha leh ta a. Zankhat chu zanriah kan kil lai chuan ka pa chuan kan unau pahnih a kan chhungkaw rilru kan tih nat ngun tawh zia te chu a rawn sawi chhuak ta a. Ka u Andrew-a chuan u a nih na chu a tlin loh thu leh kan tet lai atang tawh a ka chunga a mawhphurhna te chu a hlen loh zia te chu a rawn sawi chhuak ta a, u entawn tlak loh lutuk ka neih avanga kan pahnih a ruihhlo buaipui ta kan ni ti in ka u chu a rawn mawhpuh ta vek mai a. Andrew-a ka va en chuan a rilru a na tih chu ka hre thei a, mahse thu kamkhat mah chu a sawi ve ta miah lo. Chutah chuan ka pa hnenah keima duh thu ngei a ka ngaihdan te chu siam ka nih zia leh ka u Andrew-a mawhphurhna ka nih loh zia chu sawi in ka u thlavang chu ka lo hauh ve bawk a.

Chumi zan chuan kan mut hnu ah ka u Andrew-a chu ka room ah rawn lut in kan titi a, ka bula awm nuam a tih thu te chu a rawn sawi a. A mittui chu tla in, ka tan a entawn tur thalo tak mai a nih chu ama duh reng vang a nilo tih min hrilh a. A thaim loh a awm loh thu leh, amah hre ngai miah lo tu te leh hmun dang a mi tamtak te pawh ruihhlo ngai mi an awm ve atang te hian a mawh a nih loh zia a tih chian thu te, kei ngei pawh chung ruihhlo ngai te zing a mi ka nih ve vang te chuan amah a in thiamlo tur a nilo tih te chuan ka theih ang tawk chuan ka lo hnem ve bawk a. Khami zan khan enge a hriat pawh ka hrelo, kan naupan lai deuh atang khan tha takin min lo enkawl ta se tih thu te chu a rawn sawi a. Khatiang ang titi khan kan la neih ngai miah loh a ni a, kan neih chhun tur tih hria ni ilang chuang sawi a hun lo lutuk a sawi tawh lo tur khan ka ti miah lo tur kha ania. A tuk mai kha a hun chu alo ni dawn reng zawk kha a lo ni a.

Ka nu zing tawngtai inkhawm kal tur hi dar nga bawr vel hian a tho tlangpui a. Chumi tuk pawh chuan a tih dan ngai te in a hun ngaiah chuan a tho leh a, ka pa a rawn ko ta chul chuan keipawh chu min rawn ti harh vet a a. A aw atng chuan thil danglam tak in a thawng tih chu ka hre thei mai a, khum atang chuan ka zuang tho a

an awmna pindan lam ah chuan ka tlan phei ve ta nghal a. Ka nu chu sitting room thutthleng bul chhuat ah chuan a lo thu a, thutthleng ah chuan Andrew-a chu che miah lo hian a lo mu a. Ka nu hmel ka va hmuh chuan thil duhawm loh tak mai a lo thleng tih chu ka va hmu nghal mai a. Chutia kan buai hnu darkar khat hnu vel chuan ka u chu overdose in a boral ta a ni tih chu ka hrethiam vet a a. Tawng ngaihna pawh ka hre lova, awmdan pawh ka thiam lo, ka bo deuh ruai hian ka in hria a ni deuh ber mai.

Ka u a boral tih han pawh mai chu ka thil tawn tawh zawng zawngah chuan a la harsa ber hial ang. A boral hnu thla phei chu a harsa leh zual khawp mai. A chang chuan ngaihtuah chiang mang lova amah han koh mai te kha ka nei thin a, a awmlo ani tih te kha ka theihnghilh thin. Ka hriatchhuah veleh keimah ah hian ruak ta riau hian ka in hre thin a. Ka ngaihtuah loh khan ka tan awm a nawm phah deuh a ka in hriat vang khan ka rilru lak pen na tur thil dang hi ka ngaihven ruai thin a. Ka damdawi khawih chhunzawm leh nachhan ber pakhat chu chumi chu a nih mai bakah ka nu leh pa te hian ka u vanga damdawi hmang ka nih loh zia hi hrethiam ve se ka duh vang a ni. A damlai a amah vanga ka damdawi khawih te an puh kha a awm tawh loh hnu pawn ka la khawih chhunzawm zel tho a. A thih hma zan khan ka u khan amah inthiam lo em em in ka damdawi tih avangin a in mawhpuh nachhan kha ka nu leh pa ten an puh vang a ni a, mahse thudik a nih loh zia hi hriatthiam tir ka duh a ni. Ka u chu a awm tawh lova, ka thuthlukna siam ah an mawhpuh theih tawh lova, chumai bakah ka damdawi ruih hian ka rilru a la peng a ka tan awm a nuam zawk a ni.

Hria an awm a nih chuan kei aia hre chiang hi an awm ka ring lo – Ka u kha ruihhlo ngai leh damdawi ti thin ni mah se unau in hmangaihna ah chuan a ni aia mahni nau te hmangaih a, duhsak a humhim tu an awm ka ring lo. A damdawi tih kha a fel famkim loh na pakhat ve mai a ni a, mihring tumah hi famkim kan awm chuang lo.

PARTICULARS OF THE CANDIDATE

NAME OF THE CANDIDATE	: ESTHER LALRINHLUI RALTE
DEGREE	: M.PHIL
DEPARTMENT	: SOCIAL WORK
TITLE OF DISSERTATION	: Coping and Social Support in Families Bereaved due to Drug Related Deaths in Aizawl, Mizoram
DATE OF PAYMENT OF ADMISSION	: 2nd August, 2013
COMMENCEMENT OF SECOND SEMESTER	: 18th February, 2014
APPROVAL OF RESEARCH PROPOSAL	
1. Board of Professional Studies	: 15thApril, 2014
2. SCHOOL BOARD	: 16th May, 2014
3. REGISTRATION NO. & DATE	: MZU/M.Phil/185 0f 16.05.2014
4. DUE DATE OF SUBMISSION	: 31st January, 2015

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EDUCATIONAL QUALIFICATION:

Name of Exam	Name of Board/University	Year of Passing	Division	%
H.S.L.C	Mizoram Board of School Education	2003	III	48.8%
H.S.S.L.C	Mizoram Board of School Education	2005	II	55.6%
B. A	Mizoram University	2009	II	50.5%
M. S. W	Mizoram University	2013	I	76.5%

Related Experience:

Field Work at Centre for Peace and Development (CPD): During the fieldwork at this agency the current resource availability and use, the current guidance and counseling activities, providers and beneficiaries were identified. Outcome of the programmes and activities of CPD were also determined and perceptions from workers and beneficiaries were gathered.

Field Work at Fernando Integrated Women Development Centre (FIWDC): Various activities like casework with alcoholics, group work and focus group discussions were conducted. The objectives of the fieldwork were to learn about FIWDC and it's administration, to interact with the clients & build rapport, rendering help to cope with their problems which they cannot handle unaided through Casework and groupwork and enhancing the operations of clients' ego functions whereby they move towards greater ability in handling their lives and problems.

Field Work in Community Setting (Bawngkawn South): Analysis of BPL and AAY families in the community were carried out. To identify the problems faced by the community, a community survey was conducted and the key informants were met. During this fieldwork, a community forum was also organized. In working with the targeted groups, the poor families in the community, PRAs – Needs Assessment, Seasonal Calendar, Cause and Effect of Poverty were conducted

Rural Camp (Chawilung Village): The rural camp has helped in understanding the different social structure between an urban and rural area. The needs and problems faced by the village such as lack of health facilities, lack of higher education and the need for economic upliftment were identified with the community leaders.

Block Placement at The Calcutta Samaritans, Kolkata: A month long block placement was spent at the Kamal Gazi Night Shelter, Arunoday Midway Home and De-Addiction Centre run by the Calcutta Samaritans. The main purpose of the placement was to learn the mental health aspects of substance abuse and the pathway to recovery.