CHAPTER - I

PROLOGUE: THE PROBLEM
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THE PROBLEM

1. INTRODUCTION

Drug abuse is rapidly gaining ground over the world. A UN survey for 1990\(^1\), reported that drug abuse and trafficking lessened in some developed countries but grew alarmingly in many other parts of the world. The Third World also showed big spurt in drug abuse and trafficking. Compiled by the International Narcotics Control Board, the study noted trends in different regions of the world, suggesting a drop in over all drug abuse in East Europe and of crack cocaine in North America. Drug abuse rose in South Asian countries including India, Bangladesh, Nepal, Srilanka and Pakistan. India's major cities showed increasing trends in drug abuse. According to the survey, Nepal remained a major producer of cannabis and cannabis resin much of which ended up in India. Srilanka continued to serve as a transit country for heroin from India to the West.

In the seventies it was officially reported that drug abuse in India was limited except alcohol and tobacco. However, some disturbing signs were noted which indicated deterioration in drug abuse scene. One of the recent developments taking place in this area is the

\(^{1}\) The Indian Express, New Delhi, 10.1.91.
addition of heroin to street drugs. This has complicated further the problem, because it is almost impossible to eradicate hard drugs like heroin from any area where they have firmly established. Deaddiction clinics in major cities of the country and 'huge hauls' of contraband drugs by enforcement agencies after encounters with smugglers and drug traffickers speak volumes of the enormity of the problem.

Located between the 'Golden Crescent' and the 'Golden Triangle' and due to its vicinity with Nepal India has now achieved the dubious distinction of being the largest transhipment centre for drug trafficking in the world. India's porous border with Nepal has only aggravated the situation within the country as Nepal remains a major source of cannabis and cannabis resin.

Heroin, hahish (charas), marijuana (Ganja), opium, cocaine, morphine and methaqualone (mandrax) flow in through the entry points located on the country's international borders with Pakistan, Burma and Nepal.

2. Bhim Sain, Drug Danger & Social Behaviour, p. XVI.
The 3,110 km long Indo-Pak border facilitates the trafficking of opiates and cannabis resin (hashish) into the country from Afghanistan and Pakistan which together with Iran form the Golden Crescent. Owing to its proximity to the Lahore-Kabul highway, Jammu and Kashmir remains vulnerable. Till recently the border along Punjab was dotted with numerous entry points. With the tightening of security along the Punjab border, primarily to check the infiltration of terrorists and partly to counter the narcotic threat, traffickers shifted to a relatively safer zone - Rajasthan. The Rajasthan sector has now become a traffickers' paradise.

India's transit points are fast becoming the consuming ends. Heroin and hashish are in great demand in the metropolitan cities and satellite towns. Delhi alone has 1,00,000 people who are either traffickers, peddlars, street pushers or addicts. The rot of drug addiction has penetrated into our society. The statistics presented at a seminar on drug addiction in Calcutta (March, 1988) revealed that drug addiction claims more than five lives a day in Bombay city. The menace in Calcutta has assumed a serious proportion with an estimated 50,000 persons falling prey to deadly habit every year. According to an estimate, there are more than twenty lakh drug addicts in the country.

3. Bhim Sain, Drug Danger & Social Behaviour, p.XVI.
Perhaps the worst aspect of the drug menace is that it makes its deepest impression on the adolescents and youths who are most vulnerable. The use of drugs has a strong appeal for those who are beginning their struggle for independence as they search for self-identity. The younger people have innate curiosity and thirst for new experiences. So they are particularly susceptible to drug experience. Future generations of people are being contaminated by this scourge. When a substantial percentage of any generation is victim to an addiction, it loses contributing good citizens and acquires a crippling social burden. The insidious spread of drug addiction in the younger generation of Indian society, particularly student community, assumes the most horrifying aspect of the problem.

Drug abuse has deep impact on individuals and on society. Owing to wide and extensive prevalence of drug culture man and society are facing a gloomy future. A broad overview of the use of drugs and their implications for society is an imperative need of the present time. Unless the horrendous consequences of the drug abuse are studied and understood here and now. The people of India in general, and the younger generation in particular, will full victim in increasing numbers to this dreadful malady. The youth
have always been the backbone of every society and of its well being and security and, therefore, it could not be exposed to this growing menace.

India is passing through a phase of rapid social and economic changes. Some of the conditions, which have contributed to the development of serious type of drug abuse in advanced countries, are being replicated here. During the last fifty or so years India has been moving fast in the various social processes such as industrialisation, urbanisation and modernisation. With the spread of education, particularly higher education and development of science and technology our whole way of life and style have undergone a sea difference. Our educated elites have adopted the western way of life and style. It is no surprise, therefore, that the western trends, very commonly observed in the industrialized modern societies, should be manifested in our urban populations.

2. **Drug Abuse: An Old Social Phenomenon**

The use of drugs of one kind or the other is not a new social and cultural phenomenon in this country. The use of traditional psychotrophic substances, such as cannabis and opium, among various castes, tribes and communities of great Indian culture, has been very common since ancient times. Indians have had the knowledge and acceptance of hallucinogenic substances in socio-religious
Drug addiction, a cultivated craving for the use of drugs, is one of the oldest phenomena. The societies all over the world have been using psychoactive drugs and intoxicants extracted from more than 4000 plants and flowers to cure various kinds of human disease. From times immemorial there are people who take the drugs on their own, outside of medical advice, mainly for pleasure or to avoid or decrease pain, discomfort or frustration. Besides, therapeutic and hedonistic considerations and need for escaping from the reality of life's stresses and strains have been primary motivational factors of drug abuse. In many cultures, drugs also become valuable adjuncts of socio-religious rituals. Use of psychotropic substances in various phases of life was accepted in many societies and probably did not cause any concern or create any social problem till the middle of twentieth century.

However, over the past two or three decades there has been unprecedented spread of the use of illegal drugs in all parts of the world. No nation has been immune to this devastating problem. Its nature and severity may differ to a great extent in different regions/countries. With growth and advancement of modern science and technology an increasing
number of alkaloids and drugs extracted and prepared from them, such as heroin, hashish and smack, have caught the fancy of youth and assumed the form of a youth sub-culture. In fact, no section of society has been left without deep scars of drug menace.

The drug abuse among students in secondary Schools, Colleges and Universities in India has recently assumed more serious proportions. Indian youth already influenced by Western culture, specially Beatle and Hippy culture, openly welcomed the drug invasion by smugglers and street peddlars. Along with other drugs heroin epidemic spread very fastly among the youth. In fact, it is this phenomenon that is largely responsible for widespread attention which the drug problem has begun to receive at present.

3. **REVIEW OF LITERATURE**

Several groups of workers have studied the pattern of drug abuse in the University students. Banerji\textsuperscript{4} studied drug abuse among Calcutta University students and found that the prevalence rate of drug abuse was 17.4 per cent out of which 11.4 per cent abused amphetamines.

reported that the prevalence rate of drug abuse (without medical prescription and excluding alcohol and tobacco) was 25.1%. They also studied prevalence of drug abuse in the University students (Sethi and Manchanda). Dube and Deb found an overall ever used prevalence rate of 56.2 per cent and 29.6 per cent respectively. Bhadra\textsuperscript{11} reported drug abuse as 19 per cent along with alcohol.

Most of the above mentioned studies suffer from some limitations and are really not comparable, because of the following reasons:

(1) Improper or different sampling procedures have been adopted.

(2) Drugs included vary: Some of these studies have included alcohol, tobacco and painkillers while others have not.

(3) Definitions of drug users/abusers vary.

(4) Non-response rates in most of these studies have not been mentioned.
Dayal\textsuperscript{5} reported that 5 prr cent of Delhi University students were current drug users (on regular basis or dependent). Mohan and Arora\textsuperscript{6} in a sample survey of Delhi University students showed an overall prevalence rate of 30.1 per cent for drug abuse (including alcohol and tobacco). Chitnis\textsuperscript{7} in Bombay University, and Varma et. al.\textsuperscript{8} in Punjab University, Chandigarh found the prevalence rate of abuse as 19.7 per cent and 19.9 per cent respectively. Mohan\textsuperscript{9} in a pilot survey of Delhi University students found that the over all prevalence rate of drug abuse (without medical prescription and excluding alcohol and tobacco) was 32.7 per cent. Sethi and Manchanda\textsuperscript{10} in a study of medical students in Lucknow


Though a few Indian psychiatrists and medical scientists in late sixties and early seventies made some observations on the problem of drug use and drug dependence, yet sociologists lacked interest in the subject. Sociologists and social scientists conducted several researches in various forms of deviant behaviours in the last four decades yet drug consumption as a field of deviant behaviour has remained completely neglected. They realised rather late that it was their academic responsibility to understanding the nature of drug abuse problem and its prevalence in our society. Analysing the sociological assumptions underlying the drug usage and developing a general theory or a system of propositions, that should account for drug dependence and the particular processes of drug addiction, should have been their important concern.

Some attempts in their fields have been made by Western sociologists\(^2\), but their approaches according to R. Ahuja, have come to be questioned by radical thinkers and activities\(^3\).

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It is, therefore, necessary to evolve a new paradigm and a new theory pertaining to drug abuse problem in socio-cultural context of India. Sociologists and social scientists engaged in analysing drug behaviour should explore the possibility of such an approach and the method to approach it closely.

4. NATIONAL SURVEYS ON DRUG ABUSE AMONG UNIVERSITY STUDENTS

The Department of Social Welfare, Govt. of India, sponsored in 1976 a national survey on drug prevalence on a representative basis, at seven metropolitan and non-metropolitan centres - Bombay, Delhi, Hyderabad, Jaipur, Sagar, Madras and Varanasi. The report of the Repeat Survey', 1986 could not be available. The objectives of this survey were as follows:


13. R. Ahuja, Sociology of Youth Sub-Culture, p.4

14. R. Ahuja, Sociology of Youth Sub Culture, p.4
1. To determine the pattern and prevalence of drug abuse among college and university students in selected cities in India.

2. To understand the sociological and psychological determinants of drug abuse and,

3. To suggest certain remedial measures to reduce the incidence of drug abuse.

The preliminary results of the national survey have been included in a book entitled "Current Research in Drug Abuse in India" by D. Mohan., H.S. Sethi and E. Tongue. The universe of this study were all the college students at undergraduate and postgraduate levels (excluding evening college and correspondence course students) in the selected cities. The sample size to be covered in the study was about 4200 at each centre. Uniform tools for the study and the same operational definitions were adopted. The results included (1) Percentage prevalence, (2) Percentage prevalence rate of drugs at various centres, (3) Percentage prevalence rate of drugs according to (i) sex, (ii) type of drug groups in different combinations, (iii) the type of drug use and sex and (4) Percentage prevalence rate of current users.
The survey significantly revealed at least one (feature, which was different from all the previous studies, except those which had measured life time use. The prevalence rate of all drugs except tobacco, alcohol and painkillers was far below the earlier figures cited. The drugs which are of concern to the international, national community i.e. psychotropics, opiates, cannabis, LSD were being used by much smaller percentages than talked about or estimated earlier.

Cannabis use was the only one which was observed in 10.9 per cent of the respondents at Varanasi and 8.4 per cent at Sagar. In all other centres it remained around or below one per cent. For almost all of the drugs the prevalence rates were remarkably higher among the males as compared to females. The tranquiliser rates were below 5 per cent higher in males and lower in females. It appeared from the survey data that drug abuse did not present a major problem among college students in metropolitan or non-metropolitan cities.

The use rate was comparatively higher in the residential university such as Varanasi which strongly suggested that probably staying away from home contributed
to increased drug use. This is an observation which has been suggested by some earlier studies also (Mohan & Arora, 1976, Mohan et. al. 1977, Mohan et. al. 1979). This would have to be verified from other studies to see if the students staying in hostels took drugs more than the non-hostelers, whether due to easier availability, loosening of parental control and peer group pressures, singly or jointly, contribute to its intake.

The highest prevalence rates were observed for alcohol, tobacco and painkillers in different centres. They were usually higher for boys, compared to girls. 8.5 per cent girls in Bombay took alcohol whereas in other centres the percentage ranges around two. Tobacco consumption was also found to be increasing among women, though the percentage remained around one.

In all the centres surveyed, the percentage of never users of all drugs taken together including alcohol and tobacco, was well over fifty.

If tobacco and alcohol combination was also included, the percentage of non-users was as high as ninety per cent in Madras, to as low as sixty per cent in Delhi. Tobacco and alcohol formed the commonest combination used and it provided the base for experimentation with any other
drug in combination with them. The single drug abuse figures were high, because of probable inclusion of painkillers. Even in painkillers abuse Madras and Jaipur as cities came out last. It is remarkable because either the physician compliance is very high in these cities or drug control is more strict or that respondents by tradition are abstainers, while the process of modernisation with its antecedent tensions escapes them. Above 90 per cent girls in Madras and Jaipur were abstainers while in Bombay they were sixty per cent. These percentages were higher as compared to boys. However, painkillers were consumed by higher percentage of girls as compared to boys, which probably related to their use during menstrual cycle.

Summarising, on superficial analysis the multicentred study revealed that (1) the use of drugs other than alcohol and tobacco and painkillers was low. (2) It was much more common among boys, compared to girls, though they were beginning to breakdown traditions. (3) The use of dangerous drugs, such as cannabis and tranquillisers, showed up commonly but there is no opiate use on any large scale. (4) It suggested the possibility that drug education programmes should concentrate with tobacco and alcohol rather than other drugs, for two reasons: their known demonstrable health hazards and their breaking the barrier between the user and the non-user state.
The national empirical investigation on drug prevalence was a collaborative representative psychosocial study which aimed to explore the emerging nature and pattern of drug consumption in a selected population of college and university students, assuming that this group is the most vulnerable one to drug abuse. The study presents (1) a common and tight-knit orientation of the problem of drug abuse among college students and (2) identifies a few hypotheses of sociological relevance of a fairly wide scope.

Dr. Ram Ahuja, one of the project directors of this study, was responsible for the completion of study of university students in Jaipur city. According to him the study deals mainly with three problems: nature and extent of drug use, etiology of the drug use, and strategies in societal action. According to him, the use of drugs raises three fundamental interpretations. One group interpretes it as an anti-social behaviour calling for suppressive measures against the 'criminal' users. The second group views the issue as one of personal maladjustment by troubled individuals requiring medical or psychological intervention. The third group focusses attention on the malfunctioning of social and cultural systems that produce frustrations and
lead to the use of intoxicants. Analysing different theoretical approaches used in explaining drug addiction, this research outlines a new theoretical framework for understanding of the deviant drug behaviour. Dr. Ahuja calls it a problem qualifying as one of the forms of 'deviant behaviour without victims.'

In this view, drug abuse can be studied both as a deviant behaviour and as a social problem. In the former sense it is to be regarded as an individual's social maladjustment. And in the latter sense it is to be viewed as a widespread condition that has harmful consequences for society. Unlike several western countries, where drug abuse is considered a social problem, in India, though regarded as a problem, it is not yet considered a social problem. This is because people in India do not consider the prevalence of drug abuse to be so widespread as to cause them a grave concern for some ameliorative action.

5. THE HYPOTHESES

From the various studies conducted in India on the use of drugs during the last two decades some hypotheses pertaining to drug use were derived. For purposes of our study following hypotheses were drawn up for testing:
1. Affluent students tend to experiment with drugs more than those who come from lower socio-economic strata of society.

2. Students with professional courses show a higher tendency for drug use than students with non-professional courses.

3. The rise of drugs seldom varies with the class of study (undergraduate and post-graduate).

4. Nature of drugs used varies with sex.

5. Nature of drugs used varies with the income group.

6. Students under greater degree of parental/control are less likely to take drugs.

7. The more distant the youth feel to their parents, the more likely they are to take drugs.

8. Drug users are economically as much dependent on their families as non-users. That is, drug taking students seldom try to supplement their income by engaging themselves in part-time jobs.

9. Participation in peer groups taking drugs tends to motivate youth more easily and more often to use drugs.
10. The more the students participate in alternative co-curricular and extra-curricular activities, the less likely they are to take drugs.

11. "Drug taking behaviour of students varies with their academic performance at college/university."

6. **OBJECTIVES OF THE PRESENT STUDY**

   The present study is rather limited in scope in the sense that it seeks to study the drug abuse among college and university hostelers in Jaipur city. Dr. Ahuja's first study covered college and university students, both resident and non-resident, about twelve years ago. It was repeated in 1986. Another sociological study of drug abuse among Indian youth by Tribhuwan Kapoor throws interesting light on some aspects of the problems under our investigation. The main objectives of our study are:

1. To determine the nature, pattern and prevalence of drug abuse among the students.

2. To analyse the nature and extent of prevalence of drug abuse according to the abusers' socio-demographic characteristics.

3. To determine the association of drug abuse with the personality or psychosocial behaviour of the users.

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4. To study indepth correlations of various personality, family, parental and peer group interactions facilitating or inhibiting drug abuse.

5. To suggest measures for controlling the misuse of drugs.

In brief, the present study deals with five aspects of the drug problem. It analyses processes of initiation and induction of potential youth to drug abuse, examines "causes" of drug usage, presents a systematic theoretical approach to understanding drug behaviour and suggests measures for ameliorative action on the drug scene.

7. **BASIC CONCEPTS**

Before analysing various aspects of drug usage, it would be appropriate to define precisely and understand certain basic concepts in drug abuse terminology.

**DRUG**

'Drug' is a chemical substance associated with distinct physical and/or psychological effects. From a pharmacological or legal viewpoint, a drug is any substance which chemically alters the structure or function of a living organism. But this definition is broad enough to
encompass everything from vitamin to laxatives. It is, therefore, of little practical value. Medically speaking, a drug is any substance prescribed by a physician or manufactured expressly for the purpose of relieving pain or for diagnosing, treating and preventing any disease or disorder. Here the reference is to ethical drugs\(^\text{16}\), which are advertised and promoted mainly to physicians, pharmacists and allied professionals, usually requiring a doctor's prescription. Drugs sold by chemists directly to the public not requiring a prescription (i.e. Vicks Vaporub, Aspro, Phosphomin, Iodex etc.) are known as proprietary/over-the-counter drugs. Over-the-counter drugs also include Ganja, bhang, charas, alcohol etc. which are publically sold by the licenced vendors at their shop-counters.

Medicinal drugs of modern Allopathic Therapy are sold in finished forms such as capsules, tablets, syrups, powders, granules and injectables etc.

The general belief that all drugs have some intrinsic property that automatically classifies them as

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drugs or the experts' assumption that the category 'drug' is based on a natural pharmacological reality (something as part of a natural, organic and chemical entity) do not furnish an adequate definition of a drug. No formal, objective characteristics of chemical agents will satisfy both criteria of an adequate definition simultaneously. There is no effect that is common to all "drugs" and that at the same time is not shared by "non-drugs". Some drugs are powerful psychoactive agents - they influence how the mind works, others have little or no impact on mental processes. Some drugs have medicinal properties; others have no medical value at all. Some drugs are toxic - they require very small amounts to kill living beings. Other drugs build tolerance very rapidly. Increasingly higher doses are required to achieve a constant effect. Others do so slowly or not at all. Some drugs are "addicting" - they produce a physical dependence, others are not. There is no conceivable characteristic that applies to all substances considered drugs.  

Turning to the social definition, we find that the concept "drug" is a cultural artifact, a social fabrication. A drug is something which has been arbitrarily defined by

certain segments of society as a drug. The effects of
different drugs have relatively little to do with this
definition. But it is no less real because it is arbitrary.
Society defines what a drug is, and the social definition
shapes our attitudes toward the class of substances so
described. Nothing is a drug according to some abstract
formal definition, but only within certain behavioural and
social contexts. Therefore, when any one speaks or writes of
drugs, whether layman or professional, physician,
sociologist, journalist, or politician, he is referring to a
social and linguistic category of entities, not a natural or
pharmacological category.  

When we look at drugs in a generalised and
comprehensive way, we find that it is not so much the
substance of a material that makes it a drug, but rather
some particular social definition. In broader sense, the
term is applied to the whole range of mild-altering drugs,
including aspirin and antibiotics etc.

In the psychological and sociological contexts, drug
is a term for habit-forming substance which directly affects
the brain or nervous system. More precisely, it refers to

18. Ibid. p. 19
19. Barber, Bernard, Drugs and Society, New York, Russel
any chemical substance which affects bodily function, mood, perception or consciousness, which has potential for misuse and which may be harmful to the individual or society\textsuperscript{20}. In terms of this last definition, the frequent use of drug is considered so dangerous and immoral that it aroused a variety in indignant and hostile sentiments on the part of the general public.\textsuperscript{21}

Some drugs are, however, relatively innocuous. They are not addictive; their use does not result in harmful physiological effects; and they do not produce exaggerated behaviour. Use of such drugs stands in marked contrast to tobacco smoking and alcohol consumption. Both of them are associated with distinctly harmful physical effects on the users. Yet, because of socio-cultural considerations, consumption of alcohol and tobacco is not illegal though society seeks to discourage the "vices" of alcoholism and nicotnic-habituation.

For the purpose of the present study the following drugs are included:


1. Alcohol : Bear, wine, hard liquor.
2. Amphetamines : Purple hearts, speed, methylyphedrine, Dexedrine, Ritalin, Methedrine.
6. Opium : Goli, Morphine, Heroin
7. Cocaine :
8. Pethidine :
11. Tobacco : In the form of cigarettes, cigars, pipe, bidis etc. and in the form of eatables.
DRUG ABUSE

Physicians commonly employ the term "abuse" to refer to the use of a drug outside a medical context. The term, however, conveys a moral rather than a scientific judgement. "Abuse" clearly connotes something negative or bad. But it should be noted that non-medical drug use is not invariably harmful. The non-medical taking of drugs, actually, only certain types of drugs, is undesirable, that the benefits obtained from illegal drugs are counterfeit and that they are capable of causing medical damage. However, we must not, under ideological assumptions, see only the "abusive" aspects in a drug. Sufficient data must be collected to "demonstrate" the damages of non-medical drug use. The harmful effects of non-medical use of a drug needs close investigation.22

Deviant drug-oriented or drug-using behaviour refers to illegitimate use of any one of the natural or synthetic drugs. 'Drug abuse' means both the misuse of legal drugs and the use of illicit drugs. For our purpose, 'drug abuse' can be defined as the use of unacceptable drugs so that physical or psychological harm can result.23 The "drug abuse" includes smoking 'pot' (hashish or ganja or marijuana),

22. Erich Goode, op. cited, p. 27.
23. We have largely followed Dr. R. Ahuja on this point.
taking a 'pep pill' (amphetamines), being high on 'speed' or 'trip' (taking L.S.D.), snuffing heroin, injecting morphine, getting 'kiks' (taking intravenous injection of Methedrine) and so forth. 'Drug abuse' will, therefore, be operationally defined as non-medical use of unacceptable drugs.

It has been discovered that abuse of legal drugs causes more harm than the use of illegal drugs. Of the widely abused legal drugs those requiring a doctor's prescription are potentially more harmful and cause a more serious problem than those obtainable without a prescription (e.g. Aspirin, Calmose etc.) Many physicians ignore or are unaware of the side effects of legal drugs. Sometimes the consequences of overprescribed or overused drugs are more disturbing. Overuse of tranquillisers, amphetamines and barbiturates are the examples of legal drug abuse. Three main reasons can be ascribed for abusing both legal and illegal drugs: (i) easy availability of drugs, (ii) persistent advertising and other sales promotional efforts by drug producing companies, and (iii) the common and popular desire for convenient, short-term solutions to problems or instant cures for symptoms or difficulties.24

Society's perception of 'drug abuse' keeps changing. At any given time, there are conflicting definitions of what is 'legitimate drug use' and what is 'deviant drug-taking'. Drug taking is condemned as well as defended. This is true in the case of opium and opium derivatives like thorphine, codeine etc. Narcotics like bhang, ganja, charas and marijuana have been viewed as curses of mind and as the best hope of solvation. Depressants like barbiturates and tranquillisers have their proponents and detractors. There is thus conflict about the functional and dysfunctional aspects of drugs at present.25

**DRUG MISUSE**

'Misuse' of mind altering drugs refers to any non-specific or non-medical use of such drugs including alcohol and nicotine. The main groups of drugs which are misused by people are (1) the opiates, (2) cannabis, (3) tranquillisers, (4) barbiturates, (5) amphetamines and (6) hallucinogens.

**DRUG DEPENDENCE**

The term 'drug dependence' is classically defined as a 'state of periodic or chronic intoxication, detriment to the individual and society, produced by repeated consumption of a drug." (WHO) Drug, dependents are identified on the

Ibid. p. 6.
subjectively experienced and expressed compulsion to use the drug. They indicate their inability to stay without using one or more substances of a specific category of drug and express a craving for it.

The above definition of the concept of 'drug dependence' was accepted in the multi-disciplinary national empirical survey of drug abuse among university students.²⁶

Erich Goode, however, disputes the utility of the new terminology of 'drug dependence' and the accompanying elimination of the term 'addiction', because it confuses more than it clarifies.²⁷ According to him there are drugs, both 'addicting and non-addicting' and it is not necessary that an addicting drug must cause 'psychic' or 'psychological' dependence. If one takes or is administered a truly addicting drug such as heroin, morphine, or any of the barbiturates in sufficient doses over a long period of time he/she will become addicted - that is one's cells will crave the drug, and if the drug is discontinued, he/she will undergo withdrawal sickness. It is physical dependence which is a necessary prerequisite of addiction. In contrast if one takes or is administered a non-addicting drug such as

²⁶ Mohan etc. Current Research in Drug Abuse in India, p. 3.
²⁷ Erich Goode, Drugs in American Society, p. 23.
marijuana over a period of time, nothing essentially will happen to him/her when he/she is 'withdrawn' from the drug. Continued administration of a non-addicting drug cannot be equated with dependence, physical or psychic.

It should be clear, then, that there are two quite separable components in the addiction – dependence equation. One is the direct physical action of the drug; the other is how people respond, behaviourally to the physical action; one component does not translate automatically into the other.28

**DRUG ADDICTION**

Ken Liska says that the words 'drug addict' and 'drug addiction' have been in use most often to describe a person who has become deeply involved with one of the narcotic analgesics such as morphine or heroin.29 From a medico-legal point of view addiction was considered 'a drug induced change in the physical state of an individual, such that he/she required the continued presence of the drug to function normally. Upon abrupt termination of the drug, the addict would suffer through a physical crisis, of varying degree, known as a 'withdrawal syndrome' (also termed

28. Erich Goode, *Drugs in American Society*, p.25
abstinence syndrome). The withdrawal crisis could be ended at any time by readministering the drug.  

According to this definition, then, an addict's body somehow changes physiologically so that it requires the drug for normal existence. Further, he/she develops a tolerance to the drug, so that ever-increasing doses of it have to be taken to get the desired effect. Tolerance refers to the fact that more and more drug is needed in order to produce the same effect. It has also been defined as "as decreasing effect upon repetition of the same dose of a drug." This definition of addiction is still widely, applied and is useful in describing addicts of narcotics, barbiturates and alcohol, all of whom develop a physical reliance on a particular drug, develop tolerance to it, and suffer withdrawal symptoms when it is abruptly removed.

30. Withdrawal syndrome is defined as a crisis, with varying degrees of physical and emotional severity that can accompany the abrupt removal of a drug on which a person has become dependent. Withdrawal symptoms include restlessness, irritability, stomach cramps, nausea, vomiting, diarrhea, headache etc. (Ken Liska, Drug and the Human body, p. 411.


Modern therapists claim that not all addiction results in physical reliance on a drug, and that therefore, there is not always a physical withdrawal syndrome (e.g. cocaine and nicotine addiction). Instead such drugs produce a psychic craving for the drug. Thus the term 'drug dependence' was introduced to apply to all situations in which drug users developed reliance - either physical or psychological (psychic). Tolerance is not a necessary corollary in the concept of drug dependence, which is broad and is applicable to hallucinogens and minor tranquillisers as well as hard narcotics. 33

Yet another approach, based on behaviour, has been taken to describe heavy drug involvement. Jaffe defines addiction as "a behavioural pattern of compulsive drug use, characterised by an overwhelming involvement with the use of a drug, the securing of its supply, and a high tendency to replace after withdrawal." 34

Addiction is viewed here as an extreme on a continuum of involvement with drug abuse. It can occur without the person becoming physically dependent or developing tolerance. Thus, habituation to a drug and pre-occupation

33. Ken Liska, Drugs and the Human Body, p. 8
34. Ibid. p. 8
with it are but steps on the road to overwhelming involvement. The word 'habituation' is sometimes used to refer to psychic or psychological dependence.

However, Joseph Julian maintains that some scholars prefer not to make distinctions between physical or psychological and social dependence, since there are often interrelated. Also words like 'addiction' have come to be defined in the public mind as something evil. These scholars prefer to characterise the compulsion to use a drug simply as drug 'dependence' without attempting to define its physical or psychological components.

TRADITIONALIST VERSUS POSITIVIST APPROACH

The traditionalist approach to 'drug dependence' views it as a psychic or somatic or psychosomatic illness which manifests itself as a disorder of behaviour and is characterised by the repeated and regular use of drugs. The positivist approach refers to social functioning of the user and the need and implication of social policy. From its viewpoint, "drug dependence" is defined as habituation with a drug/or drugs that interferes frequently or continuously with the users 'social and/or economic functioning and then health. Further, it adversely affects any of their life's

important adjustment and interpersonal relationships seriously enough to cause society's conscious reaction by evolving treatment programmes. The domain of positivist definition of drug dependence is wider than traditionalist definition in the sense that it encompasses the concepts of 'social injury' (injury to society besides individual's own injury) and 'social sanctions' (including legal sanctions)\textsuperscript{36}.

**HABITUAL DRUG USERS AND DRUG ADDICTS**

The term 'habituation' is used in the mental sense that one can make a habit of doing or using anything. Once the habit of using or taking some substance (including drug) is acquired one comes to think, that it is harder to quit. However, when failing to get it, he does not feel restless, uneasy or agitated as he feels in addiction. Habituation implies psychological dependence on a particular thing or substance. In psychological dependence on a drug the abuser likes the feeling of getting satisfaction from the use of drug and wants to reexperience it. He feels a definite need for the expected drug effects, a need which may be mild or intense. The drug enables him to escape from reality from his problems, anxieties and frustrations though psychological factor underlies habituation, habit is not impulsive as addiction is.

\textsuperscript{36} R. Ahuja, \textit{op. cit.}, p. 8.
Addiction has been succinctly dealt with in the foregoing passages. The characteristics of drug addiction are: (i) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means, (ii) a tendency to increase the dose (or frequency), (iii) a psychological and generally a physical dependence on the effects of the drugs, and (iv) an effect detrimental to the individual and on the society. Habituation may lead to addiction if drug is used repeatedly and chronically. The qualitative difference between 'habituation' and 'addiction' can be explained in terms of the detrimental effects and the consequences of the two. Both individual and society suffer from detrimental effects of addiction whereas in the case of habituation primarily the individual suffers from them. Consequences of 'drug habituation' depend on the personality of the user, while the consequences of 'drug addiction' depend upon the properties of the drug itself and also on factors like the setting in which the drugs are taken, reliability of supply, vagaries of personal background, drug users' physical and psychic condition, the amount and frequency of drug used.


38. R. Ahuja, op. cit., p. 10.
8. **CLASSIFICATION OF ABUSABLE DRUGS**

There is no fixed and well-determined classification of drugs. Many possible classifications on the basis of characteristics and pharmacological use of drugs have been attempted. One such classification, more commonly used, is narcotics, generalised depressants, mood modifiers, hallucinogens and stimulants.\(^{39}\) For our analysis, we may classify abusable drugs in five main groups on the basis of their effects on human body and mind. The main types are: depressants, stimulants, narcotics, hallucinogens and nicotine. Examples of some drugs with their characteristics in each \(^{40}\) are presented in Table I.1

These drugs can also be classified as psychotropic, narcotics and recreational. The first group includes anti-depressants, tranquillisers, stimulants (amphetamines) and sedatives (barbiturates) and have legitimate application in medicine. The second group includes opiates, cannabis (cannabinoids), cocaine etc. The third group includes alcohol and nicotine and aims at pleasurable and harmless fun.


<table>
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<th>S.No.</th>
<th>Class</th>
<th>Examples</th>
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| 1.    | Depressants or Sedatives | Alcohol, Barbituates, Tranquilizers, Pain-killers, Anti-anxiety drugs | 1. Relax central nervous system (CNS)  
2. Provide a calming, soothing affect  
3. Induce sleep |
| 2.    | Stimulants          | Ambhlamines                                   | 1. Relieve tensions and emotional distress  
2. Stimulate CNS  
3. Counteract fatigue or drewsness  
4. Reduce aggressive inhibitions  
5. Induce insomina |
| 3.    | Narcotics           |                                               |                                                                 |
| a)    | Opiates             | a) Opium, Codeine morphine, pathidine heroin | 1. Produces depressing affect on CNS  
2. Create feelings of pleasure, strength and superivity  
3. Increase suggestibility |
|       | Cannabinals         | b) hashish, Charas Ganja, Bhang               |                                                                 |
| 4.    | Hallucinogens       | L.S.D.                                        | 1. Produce distortions of perception dream images, hallucinations |
| 5.    | Nicotine            | Tobacco, Cigarettes, Cigar, Bidi, Snuff       | 1. Stimulate CNS  
2. Lead to relaxation  
3. Remove boredom and increase wakefulness |
9. **DEPRESSANTS OR SEDATIVES**

Stimulants and depressants cover a wide range or heavily consumed substances. Some are available to anyone over a certain age, others are available by prescription – to say, very easily available. Theoretically at least, stimulants and depressants have opposite effects, but under certain circumstances, stimulants have a sedative effects, and other circumstances depressants are excitative in impact. The depressants include alcohol, barbiturates and tranquillizers, as well as narcotics under separate type because they have important effects in addition to depression.

Sedatives relax the central nervous system, induce sleep and provide a calming effect.

**ALCOHOL**

The substance commonly referred to as 'alcohol' is actually one of many different kinds of alcohols. It is known to scientists as ethyl alcohol or ethanol. Alcohol has a depressant action on the central nervous system, as do the barbiturates and the narcotics. It is also an anaesthetic – it deadens pain in the body. The effects of liquor are highly dependent on dose. Highly concentrated drinks like vodka, gin and whisky have much more of an impact than drinks of lower alcohol concentration such as beer or wine.
DRUG IS INJURIOUS TO HEALTH
Alcohol in contrast to other drugs, is integrated into cultural mores and is believed to facilitate interpersonal relations. For some, the use of alcohol is a normal, pleasant, sociable activity; for others it is a spur to enable them to work, or a sedative to calm down, or a kind of anaesthetic to dull the pain of living.

By almost any criterion, alcohol is probably the most serious drug problem in India today, with tobacco consumption running a strong second. Other problems related to alcohol abuse are staggering, for example, mental and physical illness, disorderly behaviour, traffic accidents, crimes especially violent crimes including sex crimes etc.

It is unfair to compare the medical and social pathologies associated with alcohol with those of other drugs, for the simple reason that alcohol is used to a far greater extent. There are not only more pathologies, but more neutral and beneficial experiences with the drug (alcohol). Most people who drink alcohol moderately or occasionally find their experiences with the drug positive and rewarding; they suffer no pathology, whatsoever, medical or otherwise.\(^{41}\) The drug is typically a mild and pleasant accompaniment to meals, recreational events, social

\(^{41}\) Erich Goode, *Drugs in American Society*, p. 144.
intercourse, celebrations and even religious occasions. In small quantities it may enhance sexual pleasure, facilitate business deals, ease social awkwardness, ally tension and anxiety, increase confidence, and make otherwise drab activities pleasurable. But heavy and/or continuous doses of alcohol lessen sexual and aggressive inhibitions, cause distorted visual and sensory perceptions. It impairs judgement and creates confusion. Alcoholism is certainly a serious social problem.

Many studies have revealed the increasing alcohol abuse among young people to the extent that there are three or four times as many drinkers as other drug users.

BARBITURATES AND TRANQUILLIZERS

Barbiturates and tranquillizers, like alcohol and heroin, are general depressants of a wide range of bodily functions. Barbiturates are usually taken orally as a tablet or capsule although they can be taken intravenously too. Medically they are used in high blood pressure, insomnia, epilepsy and to relax patients before and during surgery. As depressants they depress nervous and muscular activity. They lower blood pressure and slow down breathing and heart rate. When used in small quantities, they induce relaxation, good
humouredness, and sociableness but in higher doses they make the user sluggish, gloomy and sometimes irritable and quarrelsome. Also his ability to think, concentrate and work is impaired and his emotional control is weakened. These effects resemble alcohol intoxication. Barbiturates thus become extremely dangerous when taken without medical advice. They are found to be high on the list of suicidal poisons.

Different types of persons abuse barbiturates for different reasons i.e. (1) for relieving emotional distress; (2) for supposedly increasing efficiency, through self exhilaration and animation; (3) for counteracting abuse of various stimulant drugs such as amphetamines, for example, individuals taking pep-pills (stimulants) to function in daytime and then taking a sedative to sleep at night; and (4) for obtaining heightened effects from barbiturates in combination with alcohol and/or opiates to surpass the effects of either (i.e. alcohol or opiate). \(^\text{42}\)

Barbiturates are physically addicting sometimes the physical dependence is more dangerous than dependence on narcotics like opium, morphine and heroin. Many experts consider barbiturate addiction more difficult to cure than

narcotic dependence. When barbiturates are withdrawn abruptly, the abuse suffers from cramps, nausea, delirium, convulsions and coma. Barbiturate withdrawal is even more severe and life threatening than withdrawal from heroin. It is much more likely to result in death. It, therefore, should take place over a period of several weeks and on gradual reduced dosages.\(^{43}\)

Tranquillisers are divided into 'major' and 'minor'. The major tranquillisers like Thorazine (chlorpromazine) are useful in suppressing some symptoms of mental illness and are not used, either legally or illegally, outside the context of anti-psychotic therapeutics. The 'minor' tranquillisers include a chemically miscellaneous group of sedatives, most well known of which are librium (chlorodiazepoxide), Valium (diazepam), Equanil, Methaqualone and Placidyl. They are used to counteract tension without impairing mental and physical function. Chronic use of these drugs results in physical and/or psychological dependence. The symptoms of abrupt withdrawal resemble that of barbitrates.

10. **STIMULANTS**

The stimulants include amphetamines, methedrine, cocaine, caffeine and nicotine. The most widely known stimulants are amphetamines, popularly called 'pep pills', alcohol and cigarettes/bidis/eatable tobacco preparations. The effect of stimulants on central nervous system is stimulating. The stimulants also relieve tensions, treat mild depression, induce insomnia (keep a person awake), counteract fatigue and excessive drowsiness, and lessen aggressive inhibitions.

Moderate doses of amphetamine as per medical advice can check fatigue and provide feelings of alertness, self-confidence and well being. Heavier doses cause extreme nervousness, headache, sweating and diarrhea.

Stimulants are popular among all sections of society, housewives, businessmen, students, athletes, truck drivers and others. They are usually taken orally, some (like Methedrine) are taken by intravenous injection.

Even the continued use of stimulant drugs does not produce physical dependence, though the user's body develops tolerance to these drugs. However, psychologically addicting characteristics of these drugs are evident in habituation to them for mental or emotional reasons. Long term heavy users of amphetamines are usually irritable and unstable. They
also show varying degrees of intellectual, emotional, social and economic deterioration. Abrupt withdrawal of the drug results in mental illness and a deep suicidal depression. Use of amphetamines, particularly methedrine, in successively increasing huge doses, has deep impact on the lives of users, not qualitatively different from that of heroin addiction, in fact in many ways, it is greater. They become 'speed' freaks.\(^{44}\)

11. **NARCOTICS**

Narcotics include (a) opiates: opium, codeine, morphine, pethidine, heroin, cocaine and (b) cannabinoids: marijuana, hashish, charas, ganja and bhang.

Heroin is a white powder derived chemically from morphine, which in turn is derived from opium. Opium is dried juice of poppy plant grown principally in South East Asia, Middle East (Turkey) and Mexico. All the various alkaloid products are called 'Opiates' and they include opium, morphine, heroin, codeine and cocaine. There are also a number of synthetic narcotics of which methadone and meperidine under different brand names are very popular. Cocaine is made from the leaves of coca bush and is

\(^{44}\) Erich Goode, *Drugs in American Society*, p. 134.
odourless, white crystalline powder with a bitter taste. Cannabis is obtained from the hemp plant; and marijuana is a particular form of cannabis.

Narcotics are pain-killers or analgesics. They tend to reduce sensory sensitivity — to pleasure as well as pain. They also tend to inspire drowsiness and sleep. Like sedatives they produce depressant effect on the central nervous system. They produce feelings of pleasure strength and superiority, reduce hunger, thirst and sex drive, lessen inhibitions and increase suggestibility.

Moderate doses of opiates are medically used as painkillers. These drugs reduce short term acute pain resulting from surgery, fractures and bruns etc. Larger doses depress the brain and produce sensations which may be brief or high lasting several hours.

Heroin, morphine, pethidine and cocaine are used either by inhaling (the powder) or injecting the liquified form. Opium and marijuana may be smoked, sniffed or ingested. Charas, Ganja and hashish are also smoked. Bhang ground with spices etc. is used in liquid, goli or paste form, usually with 'sharbat'.
As analgesics, narcotics are of immense therapeuitic value. But they are also, without exception, physically addicting. Besides building tolerance, they cause addiction much more quickly than barbiturates and alcohol etc. It is possible to be heroin addict within a matter of weeks. As with the other depressants, heroin has a very narrow range between, effective dose and lethal dose.  

The withdrawal symptoms vary with the degree of physical dependence. After eight to twelve hours after last dose the user shows symptoms like shaking, sweating, chills, diarrhea, nausea, mental anguish, abdominal and leg cramps. Thereafter symptoms increase in intensity, climaxing between 36 to 72 hours and then gradually diminish over the next 5 to 10 days. However, weakness, insomnia, nervousness and muscle pains may persist for several weeks.

One of the more interesting medical facts about heroin and other narcotics is that aside from the danger of overdosing, they are relatively non-toxic drugs. Unlike alcohol, the amphetamines, and the barbitrates, which are toxic to the body over the long run with relatively heavy use, the narcotics are relatively safe. The organs are not damaged, destroyed or threatened by even a lifetime of narcotic addiction.  

Withdrawal from narcotics also appears to be relatively non-life threatening in contrast with barbiturate withdrawal. 47

12. **HALLUCINOGENS OR PSYCHEDELICS**

Hallucinogens, a group of drugs, not accepted for use in medical practice are called mind-altering drugs. The well known drug in this group is L.S.D. which is a man-made chemical. It is so powerful that one ounce produces three lakh human doses. An amount literally smaller than a grain of salt can produce gross psychotic reactions in human beings. LSD may be obtained as a small white pill, as a crystalline powder in capsules or in liquid in ampoules. Usually LSD is taken orally but it may also be injected. The effect of an average dose of LSD usually lasts from 8 to 10 hours.

Hallucinogens produce distortions of perception (seeing or hearing things in a different way than they actually are), dream images and hallucinations.

There are naturally occurring psychedelic drugs as well as synthetic hallucinogens. Psychedelic experiences have been called wired and bizarre perceptions beyond

'normal' reality, exclusively subjective to the users. Some psychotic episodes have also been reported. They are extreme emotional disturbances produced by hallucinogenic drugs.

Panic reactions, depressive reactions and permanent mental derrangement can result from an attempt to withdraw from the use of L.S.D.

13. **NICOTINE**

Legally, nicotine is not a classified drug. It has no medical use. This includes cigarettes, cigars, bidis, snuffs and tobacco, smoked or chewed as eatable along with other substances, which form ingredients of 'pans' and 'pan-masalas' or 'khaini' (surti). The risk of physical dependence on nicotine, however, may be there.

Frequent or heavy use of nicotine may cause heart attack, lung cancer, bronchitis etc. Nicotine is a psychoactive drug, but its use is associated with socially and culturally established habits. Excessive nicotine use in any form causes many serious diseases, which are transmitted genetically with ever-increasing health hazards for younger generations.