CHAPTER II

REVIEW OF LITERATURE

In this chapter, the researcher has compiled all relevant studies that he has reviewed. The literature referred is mainly from journals, which are the primary source of literature and from books that are related to the field of study.

The studies that are reviewed in this chapter have been divided into the following:

1. Studies on Drug Abuse in India as well as in other countries.
2. Studies on Family.
3. Studies on Family in India.
4. Studies on Addict and Family.
7. Studies on Family Interaction and Drug addiction.
8. Studies on Family Therapy with Addicts.
Thus, this review helps understand the drug scenario in India as well as in other countries, and the various studies that have been conducted on 'Family'. Studies on Family in India has been reviewed under a separate heading, for, Indian culture in comparison to the West is more family oriented and it would be worthwhile to review the studies conducted in India regarding 'Family'. The studies on Addict and Family, mainly review the relationships in the family between parents and children, as well as among parents and children; studies on the Role, Influence of Family in Drug Addiction mainly focus on how the family conditions and factors contribute to the drug abusing behaviour in the members of the family. The next subheading, studies on Familial, Interpersonal, Intrapersonal correlates of Drug addiction, concentrate mainly on family environment, the family style, relationship between parents and other intrapersonal factors that are involved in drug abuse. How far and how much interactions in family contribute in the drug addiction of members of family are reviewed under the heading, ‘studies on Family Interaction and Drug addiction’. The review ends with studies on Family Therapy with the Addicts, which highlights the need to involve family in the Therapy of Addicts, and strengthens the preposition that family affects and is affected by drug addiction of a member in the family.

1. Studies On Drug Abuse In India As Well As In Other Countries

In the paper presented at the Indo-US symposium on alcohol and drug abuse, Schuster, C. R.,(1986) Director, National Institute on Drug Abuse, Rockville, U.S.A., states that in a 1985 National Household Survey on Drug Abuse, it was seen that more than 70 million Americans have
used an illicit drug at some time or other, 37 million used an illicit drug in the past year and 23 million used an illicit drug in the last month.

Alcohol is the most commonly used drug in the United States with more than 113 million current users. Among illicit drugs, marijuana is the most commonly used drug with more than 18 million current users. The number of current users of cocaine in 1985 was estimated to be slightly less than 6 million, approximately 3 million individuals use stimulant drugs other than cocaine for non medical purposes. Data collected over 1977-85 period showed that the percentage of Americans using alcohol remained relatively steady over the 8 year period. In 1979, marijuana use peaked in the United states, and cocaine showed a steady increase from 1977 through 1985.

The survey indicates that the number of marijuana users over age 26, increased from 1979 through 1985. This increase is attributable to the fact that many of the individuals who began smoking marijuana at a younger age in 1979 had continued to do so as they aged. In the use of marijuana among persons who have used cocaine at least once, 93% used marijuana before they used cocaine. Among individuals who used marijuana in the past month 68% had tried cocaine. In comparison, cocaine was used only by 11% of those who were both infrequent marijuana users and had not used marijuana in the last month. The study also showed that more than 22 million individuals in the United states have tried cocaine at least once in their life time. The 1987 National Survey by the United States Government showed that 500,000 of the population are heroin addicts.
In addition to drug addiction, further public health problems have developed in the U.S.A from association of heroin use and AIDS. An estimated 65% or more of the intravenous heroin users in New York city are seropositive for the AIDS virus.

According to U.S.A press reports, nearly four million Americans use cocaine regularly, there are 20 million Americans who take marijuana at least once a month and 490,000 use heroin. People in every geographic area and in every socio-economic level in the U.S. use drugs, 24-40 being the fastest growing and the largest drug using age group.

The National Institute on Drug Abuse conducted a survey which showed that 36% of the high school students in the U.S.A. were using drugs.

In Thailand, 45% of the population, according to a government survey, are opiate dependents.

It is seen that prevalence of drug abuse in India is on the increase. It is estimated that in India about 700,000 youngsters are addicted to drugs, mainly brown sugar.

Elnager (1971) reported that in the state of West Bengal there was a rate of 13 per 1000. Nandi et al. (1975) gave a figure of 0.94 per 1000 of the total population for the same state. Dube and Handa (1971) reported 22.8 per 1000 were suffering from the problem of drug abuse in Agra; of these 59.4% used alcohol and 17.5% used cannabis and the rest used multiple drugs. Whereas in Lucknow the figure given by Thacore (1972) is 18.55 per 1000. In all these studies alcohol was the
commonest drug abused, accounting for 60-98% of the subjects investigated. It was followed by cannabis in 4-20% and opium in only 0-15%.

Studies conducted by Sethi and Manchanda (1977, 1978a and 1978b) report that 25.1% undergraduate medical students, 11.5% college students and 30.4% post-graduate medicos were drug abusers. Alcohol was found to be abused maximal (51.1%), followed by cannabis (40.8%). The prevalence rate of drug abuse was 42% and 27.5% among college and university students, according to studies conducted by Muttangi (1981) from Bombay and Parameswaram and Mashinddin (1981) from Hyderabad. Singh (1979) reported that 82.4% boys and 29.6% girls are abusers of various drugs from the studies conducted in colleges of Punjab. Gupta et al. (1987) found that drug abuse is rampant among non-student youth labour also.

Sethi and Trivedi (1979) found alcohol to be the most common drug abused (82.5%), followed by cannabis (16.1%), in a study of rural population that incorporated 8 villages.

Surya (1981), found that in Pondichery 3.6% were alcoholics and drug addicts. In a survey conducted, it was found that in Kerala, certain pockets like the high ranges and fishermen of coastal belt were found to be more addicted to alcohol and cannabis (ganja). A random survey of these areas also showed 18% of addiction, while general population showed only 14/1000 alcohol addicts.

According to an ICMR (Indian Council of Medical Research) study, the abuse of drugs is more likely to increase than decrease. Also among the students, the extent and nature of the problem is serious. If
adequate measures are not taken to curb the evil, there are disturbing signs which show that the situation is likely to worsen and get out of hand. This is proved by the study of Addityarjee and Mohan, D, et al. (1984).

Venugopal and Chandrasekaran (1981) conducted a study to understand the type of family, order of birth and their possible association with different addictive habits among psychiatric patients. They took a sample of 456 males who attended the Psychiatry out-patient department JIPMER. For the purpose of their study, they analyzed the case histories recorded in the out-patient department of psychiatry.

They found that out of the 456 males, only 97 cases had addictive habits, aging 12 and above. These cases were taken as the sample for their study. The following results were arrived at:

1. cases with addictive habits appeared to be slightly more in the rural population (53%) than in the urban population (47%).

2. all the cases were found to be hailing from middle to lower middle class families.

3. the average size of the family was five.

4. representation was higher for the married category (67%) than for the unmarried (33%).

5. nuclear families had more representation (60.32%) than joint families (39.17%).
6. Middleborns were represented more (55.6%), eldest were in the second position (30.9%) and the last were in the third position. They did not find any representation for single child.

Mohan D (1984), found that in Delhi de-addiction clinic at AIIMS, the absolute numbers and the proportion of patients with heroin dependence have been steadily increasing since 1980, prior to which no case of heroin dependence was registered with AIIMS de-addicts.

A study was conducted by Rajagiri College of Social Sciences which was sponsored by the Ministry of Welfare, India in 1989: Drug abuse, Drug users and Drug prevention services in the city of Cochin was assessed. The results of the study were:

1. Out of the total population in the city of Cochin 4.02% were affected with the problem of drug abuse.

2.a. Among industrial workers, 3.75% were drug abusers.

b. Among the patients in different hospitals in the city of Cochin, 1.14% had sought hospital help for drug associated problems.

c. Among of the colony dwellers in the city, 4.35% were drug abusers.

3. The majority of the persons given to drug abuse fall between the age 15 to 25.

The study found that all its drug using respondents were males. The study also found that the use of drugs is going up and drugs are being easily available.
The National Committee on Drug Abuse (NCDAI) in its report in 1977 concludes that "there is a hard core of drug addicts in general population and drugs most frequently abused are alcohol, tobacco, cannabis and opium. Further, the problem among students is more complex and difficult and drugs most commonly used are alcohol and tobacco. The students used psychotropics to a greater extent than the general population but the use of opium and cannabis is markedly limited. On the whole, the prevalence was more among boys and men than amongst girls and women. There are however, disturbing signs that the drug abuse may be on the increase. There is no reason for panic, but no room for complacency either".

2. Studies On Family

Family is the basic unit of the society. Dysfunctions in the family can affect the society at large, by producing ineffective and malfunctioning individuals. Family system is affected by certain problems within the family relationships and thus producing family dysfunction.

Bowlby (1951) observes from review of studies, that studies in the early fifties of this century relating to patterns of interaction and family functioning indicate a point of early psychic trauma with respect to causes of certain mental illness.

Family is the scene of socialization in which cultural value conflict is translated into interpersonal patterns, predisposing to individual's illness via the path of disparagement (Cleveland and Longaker 1957).
Family, according to Goode (1964), can be understood at different levels - sociological, psychological and biological. This understanding helps to get the view of any problem in depth. Van Der Veen, Huebner, Jorgens and Neja (1970) conclude that the perception, a person has of his family is a relevant variable for the treatment of problems within the family.

Extensive literature is available on family studies in psychiatric disorders, especially schizophrenia. It would be worth while to review these before touching upon the various family researches pertaining to the families of drug addicts.

Many researchers have focused on family interactional processes to be associated with the etiology and development of schizophrenia. One of the earliest investigations was that of Fromm's (1957) who formulated the concept of 'schizophrenogenic mother'. In the late fifties many studies were carried out in which instead of the whole family unit only a part of it was taken for study. In these studies, a special attention was paid to patterns of interaction and communication amongst the family members. The investigations carried out by Gregory Bateson, Theodore Lidz et al. and Wynne et al. stand out in this field and have had a major influence on research in family studies.

Bateson and his co-workers - Jackson, Haley and Weakland (1956) evolved the concept of "double bind". This phenomenon, according to them is common in human interactions but more so in families on engendering schizophrenia offspring. Double bind statements are those in which there are two mutually contradictory but emotionally significant
messages at different levels of communication. By being exposed to double binding situations or statements repeatedly, the individuals may lose their ability to discriminate the true meanings of their own and other messages that he manifests schizophrenic behaviour.

Lidz (1956) distinguished two types of schizogenic families - "skewed" where there is a dominating, pathological figure, more commonly the mother and 'schism' where the relationships are characterized by continuous hostility and mental withdrawal amongst the members. Mishler and Waxler (1969) find the male child particularly vulnerable in the skewed type of family where there tends to be a passive weak father and a seductive engulfing mother. On the other hand, female child is the most vulnerable in 'schismatic' families, where there is an aloof and devalued mother and a grandiose and narcissistic father.

Wynne (1958), worked with families of late adolescents and young adults suffering from acute schizophrenia and developed the hypothesis that "the relationship in these families that are acceptable and may be openly acknowledged are intensely and enduringly pseudo mutual".

The families of schizophrenics do not provide such a stable environment in role structure, they are either too rigid or are too loose and ambiguous by structure, a lack of true complementarity is concealed under a facade of "pseudo mutuality" communication and interaction are disjointed and fragmented, irritational shifts in the focus of attention prevent real continuity of interaction.

Jackson (1956) and Haley (1956) and others noticed that members of dysfunctional families unknowingly keep outsiders from influencing them,
because they are unable to change. A therapist who directs them to remain as they have been, for a time, perpetuates a paradox. The family is in a situation in which it must either obey, thus having allowed the therapist to influence them or must change as the therapist ultimately wishes.

To understand the family functioning Reuben and Hills (1960) formulated a conceptual framework. They are:

i. the interactional approach

ii. structure - functional framework

iii. developmental framework

iv. situational approach.

The relationship between individual symptomatology and family interaction is shown by Minuchin et al. (1964), Ferreira et al. (1966) and Ferreira et al. (1967).

Staker (1979) have reported that interaction and symptoms act upon each other but disturbances in interaction are generally thought to proceed symptoms rather than vice versa.

Ferreira (1965) studied 125 families out of which 50 were normal families, 15 families had a schizophrenic child, 16 families had a delinquent child and 44 families with a neurotic child. They reported that normal families when contrasted with families having a patient with mental illness, were shown to have:
1. a much greater agreement in what their members liked or disliked, prior to any exchange of information.

2. spent less time in reaching of family decisions.

3. arrived at more appropriate decisions in terms of a better fulfillment of the family member's individual choice.

A number of studies, according to Doane (1978) show that parental coalitions that are disturbed and marital discord in disturbed families indicate that marital relationship is an important variable considering the pathology producing impact on the family system. A variety of types of disturbed families showed weakness in parental coalitions. This discriminates disturbed families from normal families. Doane further observes that harmony in functioning is lesser in disturbed families than in normal families. The family efficiency and effectiveness is relatively inadequate in disturbed families during a task imposed upon them from the environment. These families are less productive, they exchange less information and they have greater difficulty in arriving at decisions that are based on the wishes of their members. According to the communicative studies, the deviant communicative style plays a crucial role in producing thought disorder in the offspring.

In 1979, Staker and Jackson studied the relationship between five interaction dimensions, a) mother's punitiveness, b) other's intrusiveness, c) father's withdrawal, d) father's negative assertion, e) thwarting the child's assertion and individual symptomatology. They demonstrated that there is significant and on going relationship over time between at least one family interaction dimension and the individual symptomatology. Also, changes in
interaction were found to relate more significantly to change in symptomatology.

Interpersonal boundaries (proximity) are reliable, valid and are separate dimensions of family interconnectedness. It was found that weak generational hierarchy was associated with increased levels of psychological dysfunction for both identified patients and their siblings. Similarly, high proximity was found to be associated with psychological dysfunction, but only for identified patients in the family. This was what Beatrice (1985) found based on the study of eight families regarding the relationship between patterns of family interconnectedness and child psycho-social functioning.

3. Studies On Family In India

Studies in India initially focused on finding out the relationship between family structure and psychiatric illness.

Family structure, whether nuclear or joint, of itself need not have any relationship with mental illness or its etiology or with the mental health of the individuals comprising the family. It is the overall functioning and quality of social relationships of the individuals in the family unit that ought to determine the health outcome of the family given that the other contributory factors are constant. Epidemiological studies alone help researchers conclude that psychiatric morbidity is more prevalent among subjects belonging to nuclear families as against those found in joint families. Sethi et al. (1967) report that psychiatric disorders are of a higher percentage in nuclear families as compared to those in joint families. A significantly higher proportion of neurosis has been found
in nuclear families by Beig (1974). Delinquency (Sethi, 1976) and attempted suicide Sethi (1968), and Rao (1976), were found to be more amongst individuals coming from nuclear settings.

Dube (1970), Thacore (1971, 1975) bring out findings contrary to the above reports. They found a higher incidence of mental illness in the joint families in comparison with nuclear families.

There is no significant correlation between the type of family and psychiatric illness according to Carstairs and Kapur (1976).

Researchers correlating psychiatric morbidity with family alone, have only concentrated on its structure and seems to have taken family system performance for granted. This approach seems to be unrealistic, for, the reported morbidity is unrelated to changes within the dynamic whole.

In a study of 1084 hospital population of psychiatric cases, by Bhatti (1974), it was found that the type of family and diagnosis were two independent variables and that there was no relationship between psychiatric disorders and type of family. Many Indian researchers have studied family interactional patterns and have reported a significant difference in the psychotic, neurotic and normal families. (Sood, 1971; Krishnamurthy, 1975; Warunny, 1975; Gomez, 1975; Shetty, 1975; Bhatti et al. 1980)

In a study on neurotic families, Bhatti and Channabasavanna (1982) showed that the neurotic families have definite pathological interactional patterns at the level of communication, concern and leadership as compared to normal families.
Subba Reddy (1982), Martins (1984) are others in this field who studied the interactional patterns of families with mentally disturbed members and obtained significant differences as compared to normals.

In a study of family interactional patterns of 4 groups, namely, neurotic depression, hysterical neurosis, alcoholics and normals, Bhatti (1986) found that there was a significant difference between each group as compared with the normal group. For the depressives, the areas of dysfunction was found to be social support role and communication and for alcoholics dysfunction was found in the areas of social support and cohesion.

4. Studies On Addict And Family

Family factors play a major role in the etiology of drug abuse. Adolescent drug abuse is seen as a part of a constellation of deviant behaviours including delinquency. It is therefore worth while to review all those factors that contribute to drug abuse.

Adolescent drug abuse is viewed from a developmental perspective by many researchers. Patterns of abuse as well as early initiation can be considered as responses to or as results of experiences from birth through adolescence. Early antisocial behaviour, early experience in the family, later experiences in school and interaction with peer, implicate the etiology of drug use and abuse. Therefore from a developmental perspective, Hirschi (1969) argues that early experiences in the family are likely to influence social bonding to family.
But, Cameron (1963) states that drug use behaviour is a complex phenomenon and that it involves 3 variables, namely, drug or a toxic agent, the person, and the environment. Various studies in the field of drug abuse have brought out the critical role played by environmental factors in drug use behaviour. It has generally been recognized that environmental influences are of two types:

1. that which emanate from peer group relations.

2. and that which emanate from family environment.

There are differences in opinion with regard to the importance of these two influences in the drug use behaviour.

Becker (1953 and 1955), Ausubel (1961), Hill (1962), Valliant (1966), Goode (1969), Cohen (1971); Johnson (1973) etc. are those group of researchers who hold the view that peer-group influences are more critical. Whereas, Bender (1963), Chein (1966), Smart and Jackson (1969), Rosenberg (1969, 1971), Blum et al. (1970), Lawrence and Vellerman (1970), Smart and Fezer (1972), and Kandel (1973 and 1974) etc. maintain that the family influences are the most important environmental factors in drug abuse.

One of the significant works with parents of drug abusers was done by Hirch (1962). In his study, he had 3 mothers and one father of adolescent drug abusers in group therapy. His general impression of the psycho dynamics involved with these parents as well as case histories of each one were presented.
He identified:

1. that narcissistic mothers rejected their addict children when they did not return their love.

2. that mothers were masochistic and infantalizing and were creating a core of masochism in the child.

3. that fathers were considered weak and ineffectual providing a poor model for identification.

All these parents were seen as guilt ridden and had a tendency to project the guilt, when under stress. These parents promoted the drug use, by buying the drugs or by giving the adolescent money for the drugs. But these impressions cannot be applied to other families of drug abusers as there was no selection criteria for the parents studied and no consideration of demographic factors such as socio-economic status.

Attardo (1965) made a well-constructed and controlled study with 28 mothers of drug addicts, 31 mothers of schizophrenics and 60 mothers of normal adolescents, with matching demographic variables. The researcher created a symbiosis on "s" scale based on Mahler's concept of symbiosis and separation individuation. On the basis of their propensity for symbiotic relation during three different age spans of their own offspring, the mothers were tested retrospectively. The age spans of their children were, years 0 - 5, years 6 - 10 and 11 - 16. The results showed that mothers of all the 3 groups had similar levels on the Symbiotic Scale relating to their offspring during ages 0 - 5. However, mothers of drug abusers were found significantly higher on the symbiotic scale than the other two groups.
of mothers, in the age group 6 - 10. Again, on the 11 - 16 age group, the mothers of drug abusers were higher than the other two groups of mothers on the 's' scale, but the mothers of schizophrenics were also found to be significantly higher than the normals in this age level. The mothers of drug abusers showed a greater symbiotic need than the others. This study, measuring directly the family interaction, tends to confirm that mothers of drug addicts are over protective towards their offspring.

Studying on 74 amphetamine abusers (both male and female) Hawks et al. (1969) reported that an unstable family situation was prominent. It was found that 34 of the 74 patients had "suffered parental bereavement or separation before age 16". High pathology was also reported among other family members. It was found that:

1. among fathers,
   a. 21% had difficulties with alcohol or other drugs.
   b. 5% had criminal records.
   c. 10% had a history of psychiatric hospitalization or had consulted a psychiatrist.

2. among mothers,
   a. 7% had incidence of alcohol and drug abuse.
   b. 14% had a history of psychotic disorder.

Blum (1970) found that among families of drug addicts poor parent-child relationship was common. Their study was a major one,
which was extensive and systematic, investigating numerous family variables that seemed to be predictive of low, middle and high "drug risk" in adolescents. Prime importance was given to family value systems (including religious beliefs), characteristic patterns of interaction and substance usage.

Chambers (1970) found that out of the 168 admissions, of females addicted to narcotics, to the U.S. Public Health Services Hospital in Lexington, 54.8 percent had been raised in homes that had been broken by age 16.

In a study on the adolescent drug user, Cancrini et al. (1970) used clear criteria for identifying compulsive drug users and interviewed families of 80 adolescent drug addicts directly. It was seen that there was a high disruption of family life with 40-45 percent of the patients having an absent parent or no family life at all. The adolescents' drug problem was seen as the result of a series of mal-adaptive solutions. This study was one of the few that reported on family therapy with drug abusers.

Rosenberg (1971) studied families of 35 adolescent patients (26 male and 9 females). It was reported that 63 per cent of the addicts did not have positive relationship with their fathers. The fathers were described as being brutal or as exercising little or erratic control or as being absent. It was seen that, by contrast, 55 percent of the patient's brothers and 60 percent of their sisters had a good relationship with their father. 90 percent of the addicts and their siblings were found to have had positive relationship with their mothers. In the light of the above, Rosenberg observes that there exists a heightened degree of personality disturbance.
shown in the addicts which appear to be related more to their intense hostility towards their fathers, with whom they could not identify in a positive manner, coupled with an over-dependent bond with their mothers.

From the studies conducted by Nylander (1964), Chein (1965), Rosenberg (1969 a and b), there is evidence to suggest that adolescent drug addicts are likely to have an underlying personality problem, coming from broken homes, and having parents who are alcoholic, anti-social or mentally ill. Rosenberg (1970) states, from a study conducted on adolescent drug addicts, that drug addiction is not only a manifestation of the adolescents' personality problem or disturbance, but it is symptomatic of a wider family problem.

Haley (1973) in his 'Uncommon Therapy' says that the 'sick' (or addicted) member helps to keep the family, particularly the parents, together through allowing them to come together or unite over his incapacitated condition. If he begins to recover and begins to individuate, the parents may begin to fight or separate. So, by getting sick or re-addicted, he allows them to reunite in relation to him. He, in this sense, is a loyal son who denies himself and rescues his family, and he becomes a saviour.

Stanton M.D(1977) states in his article "The addict as saviour: Heroin, death and the family" that family wishes that the addict was better off dead than being in jail or lost to others. The strong death wish and instruction to die are obvious along with the willingness by offspring to sacrifice themselves.

It is assumed both by the addict and family that he cannot stop taking drugs and that he is not responsible for his behaviour when
he is under the influence of drugs, says Schwartzman (1975). He further says that the addict and his family believe that he is unable to resist drugs if exposed to them. The feeling of powerlessness against drug in the addict is reinforced by the family members.

Alexander and Dibb (1975) on their studies on addict families in Vancouver, came to the following conclusions that can be applied to large majority of the families.

1. The parents are more successful in meeting reality demands than the addict. Addicts, on the other hand, could not keep jobs or generally attend or take care of their personal matters.

2. Relationships in families are harmonious and conventional but there occur frequent nagging and occasional explosion of rage.

3. Addicts do not help their parents in running the household or discontinue their use of drugs or their association with drug users. Addicts make promises, excuses, nag and accuse parents to obtain money and other concessions.

4. Husbands appeared to dominate wives.

5. Parents used their money and energy to indulge the addict and the addict depended heavily on the parents to meet his needs.

6. Parents tried to control many aspects of addict's behaviors, but they did not help the addicts to acquire adult skills and attitude or to take realistic steps towards independence.
7. Both the parents and addicts shared the perception that the addict is a failure.

Alexander and Dibb (1975) go further to speculate that the parents in addict families seem capable but are socially isolated and shallow. The addict, as a child plays roles like that of a charming facilitator of family interaction in an otherwise dull family or the role of an exceptionally talented child on whom the parents focus their affection, hopes and indulgence.

According to Banks and Kahn (1975), family therapist may have overlooked the importance of the sib subsystem. They argue that well siblings may be used to keep the family in "uneasy but stable balance". Further, they say, it is the therapist's task to remove a non-symptomatic sib from this position.

Singh and Broota (1978) carried out a study on student groups to evaluate the role of family environment in drug-use behaviour. They found that the drug taking subjects in their sample, in general, hailed from families with positive history of smoking, alcohol drinking and drug abuse among fathers and siblings. (It has to be noted that absence of drug habit in mothers may be due to the Indian socio-cultural tradition).

This means that students with a positive family history of smoking, alcohol drinking and drug abuse are more likely to indulge in drug abuse under peer influences than those who do not have family history of these habits. This study by Singh and Broota confirms Kandel's (1973 and 1974) statement that parents using drugs or alcohol, may neither be necessary nor sufficient for the drug-use behaviour in adolescent to
develop. But, in a situation where peers use drugs, parental behaviour becomes important in modulating peer influence. Therefore, when their friends use drugs, children of non-drug using parents are less likely to use drugs where as children of drug using parents are more likely to do so.

Sibling sub system holds an important place in the structure of the family. Families will react differently in a given situation depending upon which siblings are present or involved (Mishler and Waxler 1971).

Cleveland (1981) has made a structural analysis of children’s roles in families experiencing drug related problems. She says that siblings of a child/adolescent with drug problems take on roles that play a specific part in maintaining the symptomatic family structure. These roles are intense and rigid and play a part in supporting the inflexibility of family response patterns and in deceleration of family conflict. In some family, Cleveland observes, several of the roles may cluster in one child; in other families they are clearly differentiated among children.

The roles with major structural impact played by the siblings of the drug users are:

1. **Parental child:**

   The parental child (PC) is typically an elder child who becomes directly involved in decision making related to his or her drug abusing sibling.
2. **Good child:**

The good child (GC) is the child who achieves and who succeeds in carrying out normative, overly stated values of the family. Usually, there is only one good child in the family.

3. **Symptomatic child:**

Symptomatic child (SC) is a child whose behaviour appears to be out of control and whose family structure has a particular form. Some symptomatic children take on the role of the sick child, and some become bad.

Cleveland (1981) also gives some auxiliary roles that have considerable impact on family functioning.

1. **Child Advocate:**

It is the one who is the spokesperson for the sibling subsystem and advocates for children's rights. This role is frequently carried by the symptomatic child, sometimes by a less involved sibling.

2. **Child Analyst:**

It is the child who analyses the sib subsystem and the subsystem of parent and child. They have a clear view of the marital system's effect on the family as a whole, often one child will stand out as analyst.

3. **Child peacemaker:**

It is the one who tries to keep the family peaceful. Often he/she acts as go between among the sibling, parent/child, and marital subsystem.
4. Child therapist:

This child has a sincere desire to improve family functioning. Child therapist recognizes the seriousness of family problems and wants to get help.

Haastrup (1972) conducted a study with the parents of young (less than 25 years old) drug abusers who had been hospitalized for a diagnosis of either drug dependence or psychosis with drug intoxication. A normal group of adolescents were evaluated in another study and the drug group was compared with this normal group. The result for the whole group showed an increased number of broken homes, increased age of father, increased psychiatric admission for the mother, increased misuse of alcohol for the fathers and increased use of psychoactive medicines for the mothers. This study, however, did not differentiate compulsive drug abusers from more sporadic users. It is difficult to ascertain the reliability of the data. Also the family dynamics were crudely measured.

Reilly (1979) reports that the common characteristics found in families with adolescent drug abusers were negative communication patterns (criticism, blaming, lack of praise); inconsistent and unclear behavioural limits, denial of the child's drug habit, unrealistic parental expectations and miscarried expressions of anger.

Family Environment Scale (FES) was administered to 73 opiate addicts whose mean age was 28 years, who were admitted to an outpatient naltrexone programme, in a study conducted by Kosten Thomas et al. (1984). Results indicated that the subjects' perceived family environment differed from normative sample. It was seen that they
perceived their families as providing little preparation for social roles, while expecting high achievement. Results of this study indicated that the subjects' perceptions of their family environment demonstrated significant discrepancies from the perception of their wives and mothers and from ratings of their marital behaviour.

In an investigation conducted by Openshaw (1984), two contemporary theoretical explanations of adolescent self-esteem, symbolic interaction and social-learning were compared. It can be stated from the findings that adolescent self-esteem was more a function of the reflected appraisal of the parents than it was of adolescents’ modelling their parent’s self-esteem. Female adolescents were more influenced by their parents compared to the male adolescents.

Twenty six, 13 - 19 year old drug-abusing adolescents and their families with 26 non-drug abusing adolescents and their families were compared by Rees Constance et al. 1984. This was done on the measures of adolescents' self-esteem and perceived parental behaviour. Results show that the adolescents’ self-esteem and perception of parental behaviour, the ability of the parents to predict the child’s behaviour, parental perceptions and the professed parental attitudes towards confidence and responsibility in child-rearing, all combined to suggest a set of factors differentiating the drug abusers from the non drug abusing adolescents.

Carbonell (1984) has discussed relationship of drug addicts with their families of origin while growing up and as adults, citing results of interviews with young drug addicts and non-addicts. In the study cited, no significant difference in family relationship was found between drug
addicts and control subjects, although various authors have postulated that drug addicts have pathogenic parental relationship.

In his review of the past work done in the area of the family's role in drug abuse, Glyn Thomas (1985) presents research findings that are relevant to the family environment and adolescent drug use. Birth order, family size and family make-up, particularly in families with divorced parents are suggested as variables needing further assessment with regard to their relationship to adolescent drug use.

Friedman (1987) studied 96 adolescent drug-abuse clients and their parents. They were administered the FACES instrument, based on Olson's Circumplex Model of Family Functioning. The purpose of the researchers was to report how family therapist perceive families of adolescent drug abusers with regard to the dimensions of "cohesion" and "adaptability", compared to how these same families are perceived by the family members (mothers, fathers and the adolescent drug-abuse clients). In this study, the perceptions of the families of drug abusers, as perceived by three different family members, were compared with each other, and comparison of families' self-ratings to Therapists' ratings of the families were made. It was found that perceptions of parents and the drug user differed and the therapists too differed from the adolescent drug user in their categorizations of the families.

Friedman (1987) found that majority of these families considered themselves as "disengaged" (rather than enmeshed) on the cohesion dimension, and as "rigid" (rather than chaotic") on the adaptability dimension. These
findings are substantially different from other published findings, according to Friedman et al.

5. Studies On The Role or Influence Of Family In Drug Addiction

Many researchers (Attardo, 1965; Millar, 1974; Reilly, 1975; Tolone and Dermolt, 1975; Cancrini et al. 1976) have focused their studies on the families influence on those who use drugs in order to help the practitioner focus his or her attention on the potential drug abuser and to make intervention more effective putting an end to drug use before it goes out of hand.

The intensity and the importance of the addicts' ties to their families of origin are supported by considerable evidence from various studies conducted. Valiant (1966), found that 72% of the addicts in his sample still live with their mothers at age 22.47%, who were 30 years of age lived with a female blood relative. Noone and Reddig (1976) found that 72% of their 323 clients (average age was 24.4 years old) either presently lived in their families of origin or had done so with in the previous year. Ellingwood, Smith and Valliant (1966) and Stanton (1978) in their studies found that addicts maintained close ties with one or both parents up to and beyond age 30.

With the help of observations of family interactions and rating scales, Singer (1974) examined the relationship between a family's use of discipline and delinquent behaviour in their adolescent children. He proposed three components of discipline:
1. Policy - how disciplinary rules were formulated, what the rules were.

2. Policing - how behaviour and compliance with the rules were monitored.

3. Punishment - what were the consequences of non compliance.

Enduring family system structures were thought to be reflected by the "configuration" of the policy, policing and punishment components and family interactions related to these. He studied 30 families with hospitalized adolescents. He observed four types of disciplinary configurations. Each type was seen to correspond to a type of behavioural disturbance in the adolescent. It was observed that a configuration of very restrictive policy, lax policing and lenient punishing was common among families of delinquents. This finding contrasts with the common presumption that parents of delinquents are simply too permissive in their disciplinary policies. According to Singer, although each parent's disciplinary messages to the child were consistent across time, as a subsystem they dictated different and conflicting actions to the child. It was at the interface of the parental and child subsystems that inconsistency occurred rather than between each parent and child, and evidenced itself only during family interactions.

In studying the basic patterns of familial interaction of 78 patients, Kaufman and Kaufmann (1979) found that 88% of mother-child relationship were enmeshed. Therefore, the extreme closeness of the addict to his family of origin would evoke a fear of separation.
Haley (1977) brought out a notion of triangle in which there is a coalition between two people at the expense of a third (between father, mother and addictive child). The addict, therefore, is embedded in the relationship of the parents. The addict is punished for choosing sides and at the same time punished for not choosing sides. The addict, in order to escape the family without actually leaving, handles the dilemma by taking drugs.

Steinglass (1979) has identified five concepts that will aid the understanding of the circular causation and dynamic process of family systems with a chemical abuser.

1. Family as a system:

The entire family is an interactive system whereby all members affect and are affected by one another.

2. Homeostasis:

The family system has built-in mechanisms and rules that resist any change from the established sense of stability and predictability. Therefore, any serious change in the stability of the family affect the members deeply.

3. Identified patient (i.p) as a scapegoat:

The symptom is viewed as a family process as opposed to an individual process. By bearing the stress for keeping the family homeostasis, the identified patient provides a protective function.
4. **Communication patterns:**

The structural and interactional patterns that govern the family behaviour are reflected by the patterns of communication in the family.

5. **Transformation:**

Families have a built-in mechanism to change so that it can adapt to changes within the family as well as the environment.

Madanes, Dukes and Harbin (1980) through their research, come to conclusion that the addict is given a powerful role in the family. The addict's job is to defuse conflicts and divisions between parents or in the family. Therefore, any deviance of the addict is a welcome event in the family, otherwise the family would get separated.

Many studies show that family size and birth order are those family characteristics that have systematic effects on child development (Falbo and Polit 1986). A number of broad family-based variables considered in various investigations have been found to be determinants of drug use. They are socio-economical level of the family as measured by parental income and education (Fawzy et al. 1987, Simcha-Fagen et al. 1986). Use of drugs in the family, including alcohol, (Kumpfer 1986) and the stability of the family are measured by the presence or absence of the parents (e.g. Blechman et al. 1977).

Family conditions influence the optimal development in children. Bell and Avery (1985) Kidwell (1981); Scheck and Emeric (1976) have all found that there is diminished parenting effectiveness with increasing family size. Family size was found to be correlated with self-reported maternal
distress and with the percentage of negative parental interaction with children (Conger, McCarthy, Yang, Lahey and Kropp; 1984).

Family factors contribute to antisocial behaviours as is shown by many studies. Croughan (1985) reported that individuals with an anti-social personality were more likely to have relatives with either a history of alcoholism or characteristics of an anti-social personality (e.g. Cahalan et al. 1969; Cloninger et al. 1975, Kumpfer 1967). Marital disruption was reported (Kinard and Reinherz, 1984) to be associated with such anti-social behaviours as social withdrawal and frequent expressions of hostility. Family disruption and low levels of education are related to decreased subsequent employment and more criminal involvement (Simpson, Joe, Lehman and Sells 1986). Male delinquency was found to be associated with a lack of family intactness and with a lack of closeness to parents (Kandel, Sincha-Fagan and Davies). From the longitudinal study of 557 teen-agers by Newcomb and Bentler (1986) it is reported that the emotional distress and somatic complaints of mothers increased the perceived family disruptiveness, which in turn, increased the teen-agers’ tendency to be socially deviant and to use drugs.

Research findings have shown that substance use by children is often preceded by poor relations with parents (e.g. Pandiana and Schuele 1983). Sowder and Burt (1980) report that children of substance-abusing parents show evidence of impaired cognitive and verbal abilities, Herjanic et al. (1977) Rimmer (1982) report that they show more academic problems and according to Gabrielli and Mednick (1983) more frequent learning disabilities are shown.

According to Levison Gerstein and Maloff (1983) the commonalities in substance use behaviour are more impressive than the differences and that the differences that do exist are likely to be differences of degree rather than qualitative differences.

Helzer et al. (1975) Robin and Ratcliff (1979) find that Heroin addicts, as compared to non-heroin addicts, are more likely to come from single-parent families, from divorced families and from families where there are members who were incarcerated for drug-related problems. Kandel, Kessler, Margulies (1978); Sincha-Fagan, Gerston and Langner (1986) report that parental marital conflict, lack of parent involvement with their adolescent offspring and parental lack of love affect the subsequent young adult narcotic use (or probably addiction though it has not been reported). In a case control analysis of 100 heroin addicts by Baer and Corrado (1974), it has been reported that compared to non users of heroin, the addicts were more likely to have come from broken homes, to have experienced severe physical punishments from parents or guardians and to have experienced a lack of parental concern in the areas of School, sexual conduct, friends and career guidance.

There are other studies that report on the various family factors that influence drug addiction/use. Kolp et al. (1972), Tec (1974), Cannon
(1976) report that many of the pressures affecting the drug user stem from marital conflicts between adolescents' mother and father. Fathers with psychological problems and who are irresponsible in their marital relationship contribute to drug use (Timms et al. 1973). Many researchers have found a correlation between broken homes and drug use (Braucht et al. 1973; Johnston, 1973; Tec, 1974; Cannon, 1976), and alcoholism (Amark, 1951; Pittman and Gordan 1958; Park 1962; Robins et al. 1962) and drug addiction (Rosenberg 1969, Bell and Chambers 1970). Haastrup and Thomson, 1972; Soresky, 1977. Father absence is another particular detrimental factor to male children and adolescents who become drug abusers (Fort, 1969; Torda, 1968; Bell and Chambers, 1970). Chein et al. (1964) report that many drug abusers found that even if their fathers were physically present, they were often emotionally absent. There was very little closeness perceived by drug users between themselves and their parents (Kaplan and Meyerowitz 1970, Streit and Olivier 1972; Tolone and Dermott 1975; Barnes 1977). The inadequacy of parental role performance exacerbates the lack of closeness and mutual rejection (Sedlin, 1972; Robins et al. 1962).

Bron, (1975) and Sorosak et al. (1976) have found that both drug users and their families lack the ability to communicate effectively. Double messages are frequent in families with drug users, which creates a major parent-child communication gap (Cannon 1976).

The type of discipline enforced by parents also influence drug use/addiction. Several studies (Fort, 1969; Laskowitz 1961; Wolk and Diskind, 1961; Wittenborn, 1970; Schultz and Wilson, 1973) have shown that there is a direct correlation between laissez-faire discipline and drug abuse.
It was also seen that although the parents granted drug users autonomy, they were hostile and indifferent towards the drug users (Streit et al. 1974). Purdue Public Opinion Panel (1969) Haagen (1970) Cross and Davis (1973) Miller (1974) Serednesky (1974) found in their studies that there is correlation between authoritarian discipline and drug abuse. Some studies have found that the drug user’s family may use either laissez-faire or authoritarian discipline (Chein et al. 1964, Braucht et al. 1973; Tec, 1974). Hirsch (1961); Ellinwood et al. (1966) have indicated that among families of drug users, both Laissez-faire and authoritarian discipline may be used. Thomas and Weigart (1971), Cannon (1976) and Blum et al. (1972), have shown that parents who used democratic mode of discipline produced fewer adolescents who used drugs than did parents using other types of discipline.

The drug or alcohol habit also plays a major role in the influence on addiction. It is seen that most teen-age alcoholics have a parent or parents with alcoholism problems (Robin et al. 1962, Robins 1966; Widseth and Mayer, 1961; Barnes, 1977). It is also reported that there is a high incidence of alcoholic parents among drug addicts (Ellinwood et al. 1966; Torda, 1968; Rosenberg, 1969; Haastrup and Thomas, 1972; Bratter, 1975). It seems that parents who abuse drugs such as alcohol often produce adolescents who use their own drugs, such as marijuana (Weing et al. 1970; National Commission on Marijuana and Drug Abuse, 1972; Josephsen and Carroll, 1974; Tec, 1974). It has been found that parents (Cohen, 1976) as well as siblings (Bowker, 1976) serve as models of drug abuse.

According to the hypothesis of Smart et al. (1970), the drug use patterns of fathers may have a more significant effect upon adolescent...
drug use than mothers’ drug use. Haastrup and Thomas (1972) emphasized maternal drug use. Some researchers have noted no significant correlation between parent and adolescent drug use (Kandel, 1975). It is also reported that parental drug use had a greater effect on adolescent pill-taking than on adolescent marijuana use (Josephsen and Carroll, 1974). According to studies conducted in America by Nail et al. (1974) there is a link between parent and adolescent drug use and seem to be different for black and white subjects. Schultz and Wilson (1972) report that parental drug use affected adolescent drug use only if certain other family conditions existed. They found that there is little drug use among lower class black adolescents if a non-drug abusing mother was the family’s principal source of income, regardless of the extent of the father’s drug use. Although there is relationship between adolescents’ and parents’ drug use, this relationship is a complex one and may have a strong interaction with other factors.

Parents learned to escape responsibility by taking drugs and so act as responsibility avoiding models for their children (Braucht et al. 1973). Parents are found to transfer their own deviant norms to their offsprings (Amark, 1951; Rosenberg, 1970). Various studies mentioned above throw light on how family influences drug use/addiction. Jurich et al. (1985) emphasizes the role of discipline, communication, drug taking, denial and the interaction of perceived power and the use of "psychological crutches" in the family in creating drug users and abusers.

Family environment is very important in determining the psychological and social adjustment of children.

Many variables are found to be associated with anti-social problems. There are households that are disorganized and have poorly defined rules and have inconsistent, ineffective family management techniques.

Loeber and Schmaling found that in a sample of 195 boys, who were involved in both overt and covert anti-social behaviours came from families with the greatest disturbance in child-rearing practices.

Adler and Lutecka (1973); Wechsler and Thom (1973) report that in adolescent drug use, positive family relationships, involvement and attachment, appear to discourage the adolescents' initiation into drug use.

Kirschenbaum, Leonoff and Maliano (1974) studied the functional relation between the individual and socio-cultural systems and the adaptive function of drug use in the face of stresses in modern American society. They highlight characteristic family patterns observed in families with a drug-using member. They found that, drug was used by individual to protect himself from the painful feelings aroused by his family situation. This was considered to be functional for the individual.

The relationship between drug use and factors like broken home or loss of a parent has been given considerable attention. Stanton (1979) reports that the majority of drug abusers do not come from broken homes. Therefore it is important to look beyond the absence of one or both
parents to understand more fully the relationship of family factors with drug abuse. Studies by Kaufman and Kaufmann (1979), Staffenhagen (1980), Stanton (1979) all found a relationship between drug abuse and both over-involved, over-protective parenting and detached, neglectful parenting. Parents of drug abusers are seen to provide fewer behavioral controls than parents of non-users (Jessor, 1976; Lukoff 1980). Whereas it has been found that greater parental control (e.g. parents who made rules about friends and who made unilateral decisions) was related to drug use, other than marijuana (Kandel et al. 1980). Controls and extreme indifference are both related to marijuana use (Tec. 1970).

Glynn (1981) concluded, based on a review of a number of research studies, that a reasoned, democratic parenting style appeared to reduce risk of drug use, whereas both very permissive and very strict controlling styles may promote drug use.

There are many research studies focused on family structure, family dynamics, family problems and adolescent drug abuse. Friedman et al. (1980) found association between adolescent drug abuse and family "break down" events (death, parents’ separation and divorce, lack of cohesiveness and parental drug or alcohol use, family problems).

Pandina and Schuele, 1983; Duncan, 1977; Bruns and Geist 1984; have found that higher levels of stress is associated with adolescent alcohol and drug use. According to Coleman (1980) families with a drug-abusing member are characterized by loss, unexpected or untimely death; and multi-generational chemical dependency (Stanton, 1979; and Stanton, Todo and Associate, 1981), emotional enmeshment (Noone and Reddig, 1976;
Madanes, Dukes and Harbing, 1979). Killorin and Olson (1984) found that families with a dependent family member were extreme on two critically important dimensions of family life: cohesion (degree to which family members are separated from or connected to the family) and adaptability (flexibility of family system to change) when compared with families with no member abusing drugs.

McCarthy and Anglin (1990) studied the family background characteristics of 756 male heroin users to determine the effects of selected family risk factors on the timing of onset of emancipation and drug use, on pre-addiction incarcerations and on educational attainment. The risk factors included:

a. family size
b. birth order
c. socio-economic status
d. family drug use
e. parental history of alcoholism
f. parental absence
g. family history of incarceration.

The two age measures of emancipation adopted by the researchers were: 1) age on leaving school and; 2) age on leaving home. Also age of onset of regular use was measured for tobacco, alcohol, marijuana and heroin. The occurrence of juvenile detention and the time spent in
prison prior to the first addiction were included in the Incarceration Measures. McCarthy and Anglin (1990) found from this study that in a child's formative years the quality and quantity of adult supervision has long term consequences with regard to the child's ability to succeed. They report that larger family size, higher birth order, parental alcoholism and parental absence have a cumulatively negative effect on the quality and quantity of parental supervision that a child might obtain.

Reilly (1985) studied adolescent drug abuse as symptom of family system dysfunction. According to him, it is contended that adolescent drug abuse reflects a defect in the normal family "launch sequence" by which the adolescent is prepared for gradual disengagement and separation from the family of origin. Malfunctioning patterns of interaction that are characteristic of families of drug abuse are discussed, such as parental denial and inability to set consistent limits.

Interpersonal factors (parents' and peers' drug using attitudes and behaviours, characteristics in the relationship between parents and adolescents and among peers) and intrapersonal factors (self-esteem, depression, coping, sensation-seeking factors) have an impact on behaviour of members. Many researches have been carried out in these areas. It has been constantly reported by the researchers:

1. that adolescents whose peer group uses substances are more likely to use drugs and use more frequently than those whose peers are non-users and peers, relative to parents, have a greater influence on adolescents' drug using behaviour (Needle et al. 1986; Hundleby and Mercer, 1987).
2. that adolescents in whose families one or more members smoke, drink or take drugs are more likely to use substances than those adolescents whose family members do not use substances (Barnes, Farrell and Cairns, 1986) and,

3. that adolescent drug use is related to the qualitative characteristics of relationships (parental orientation relative to peer orientation, lack of perceived warmth, perceived closeness to parents), (Kandel, Kessler and Margulies, 1978; Jessor and Jessor 1978; Brook, Whiteman and Gordon, 1982; 1983; Hundleby and Mercer, 1987).

Alexander and Dibb (1976) devised a technique called the "Interperception Matrix" to investigate interpersonal perception in eight families in which there was a close tie between the parents and the addicted offspring. Eight controlled families were also taken to compare with the addict families.

They found several differences between the two types of families. In addict families it was found that:

a. addicts, their fathers, and their mothers, all held the addict in low regard;

b. addicts were described as very different from their parents;

c. parents and addicts disagreed more in their perception of the addicts;

d. both the parents and addicts agreed that the addicts' major flaws were passivity and dependence;
e. the addicts' mothers described themselves as less agreeable and more passive.

Psycho-social process of modelling, identification and social reinforcement have been seen to have considerable value in accounting for the influence of parents and peers on adolescent drug using behaviour (Kandel, 1980; Akers et al. 1979; Barnes et al. 1986; Brook, William, Gordan, Nomura and Brook, 1986) and these processes may have differential importance relative to initiation and continuation of drug use (Akers et al. 1976). Kandel, Kesser and Marguiles (1978) report that while adolescents may not specifically imitate their parents' use of particular drug, they may learn that one method of coping with psychological stress is the use of drugs. Akers et al. (1979) point out that after initiation the consequences of use, including the actual effects the person has previously learned to expect, determine the probability of continued use.

There is empirical evidence to indicate that intra-psychic distress (e.g. depressive mood) is associated with high stages of drug use (Brook et al. 1986) and that adolescents use alcohol and drugs to cope with feelings of depression, to relieve the tensions they feel and relax and also to get away from problems (Johnston and O’malley, 1986). Lettieri (1978) saysthat the social learning/socialization perspective overlaps with the coping self-medication perspective, suggesting that using drugs is one alternative to cope with the stresses and strains of every day living; he further states that using drugs to cope is a learned behaviour, as are more constructive coping strategies and that drug abuse occurs when other coping strategies fail.
In addition to stress and coping, other intrapersonal characteristics found to be related to drug use are unconventionality (Jessor and Jessor, 1980; Brook, Whiteman and Gorden, 1982) and self-esteem (Kaplan, 1980). Drug use was also found to be associated with a number of intrapersonal factors - early use of alcohol, poor self-esteem, depression, deviance, sensation-seeking and interpersonal factors - peer drug use, adult drug use, and relationship with parents. (Newcomb, Maddahian, Bentler, 1986). Therefore the greater the number of these risk factors, the greater the likelihood of using drugs and the frequency of use of a range of substances. A linear relationship between number of psycho-social factors and the extent of drug abuse was found by Bry, McKeon and Pandina (1982).

Needle (1988) conducted a study with adolescents (drug using and non using) and their families. They found the following:

1. Clinical families (with drug using adolescents on treatment) were characterized by greater use of substances by mothers, parental divorce, adolescent's and peer groups early drug use and low family cohesion.

2. Non-clinical families (with drug using adolescents who are not on treatment) revealed no differences on any of the familial, interpersonal and intrapersonal factors.

3. The non-drug-using adolescents/families were characterized by low parental divorce rates and higher levels of cohesion and flexibility compared with clinical and non clinical drug using groups.
These findings confirmed the results of the study of Olson and McCubbin (1983) in which strong families were characterized by high levels of cohesion, flexibility and ability to solve problems together, to cope effectively with stress, and to listen and share feelings. In addict families, addict offspring are perceived as having the kind of traits that are incompatible with success and independence in a competitive culture (Alexander and Dibb, 1976).

7. Studies On Family Interaction And Drug Addiction

Family interaction has been viewed with interest by many researchers. Family system has a significant role in maintaining a substance abuse problem (Steinglass, Weiner and Mendelson, 1971). In one of the few studies in which the addict and parents were tested together, Mead and Cambell (1971) matched twenty family triads, including both parents and one drug abusing child with 20 normal families for age, race and socio-economic status. Decision making tasks based on a modification of Ferreira and Winter’s test items were given to the families. Family members were tested individually first. A group of families was tested to find out how much time they took to come to a decision. It was seen that there was a significant increase in the amount of spontaneous agreement or "value consensus" for the normal families. It was found that, with all families, children tended to have greater agreement with the parents of the same sex. No significant difference was found for increased spontaneous agreement between mother-child dyads and father-child dyads in the drug abuser’s family. The result arrived at was that families of drug abusers were similar in their lack of spontaneous agreement with families of schizophrenics, maladjusted and delinquent children. Discussion
of disagreement tended to be avoided even though present, and, that discussion
time was spent inefficiently talking about areas already agreed on, in the
family with a drug abusing member. This study attempts to measure the
dynamics of the interacting family.

Another study on family interactions by Hetherington et al. (1971), found that family interaction differed by sub-groups of delinquents. It was seen that in the families of neurotics, the mother played a dominant role and marital conflict was extensive. Sons in these families were withdrawn and conflicted only with their father. Fathers dominated in families of the socialized-aggressive delinquent, while mothers passively resisted solution of problem at hand. The sons in these families were seen to be active in conversation, but unwilling to compromise. In the families of unsocialized psychopathic delinquents, father dominated the scene and communication patterns were confused. The sons were relatively uninvolved in decision making process, except to disagree with one parent usually the mother.

In a study on the interaction styles and shared social perceptions of families of delinquents compared with those of normals and schizophrenics, Reiss (1971) reported that delinquent families differed from others because they had the tendency to regard the environment as disjointed as though its components were not related. Family members were frequently emotionally isolated from each other and they lacked knowledge about other family members' motives and viewpoints. The intra-familial co-ordination of behaviour was low and problem solving was poor. These families were labeled as "environment distance sensitive", by Reiss. He states that normal families differ from delinquent families mainly in their
familial interdependence and expectations that the environment is predictable and reactive to their needs. Kirschenbaum (1974) considers drug use as functional for the individual in that he protects himself thereby from painful feelings that one aroused in his family situation (especially protecting his individuality from external intention) and provides himself with some form of validating experience or nurturant that is not available within the family.

Stoker and Swadi (1989) report that drug users saw their families as distant, insulated with frequent parental disagreement and conflict and there was difficulty in communicating with both Parents who are perceived as mistrusting, verbally punitive and critical.

Age and gender of the substance abuser, life cycle stage of the family, phase of substance abuse and dependence, socio-economic conditions and psychopathology are those factors that interact with the effects of substance abuse to produce a disordered family system (Kaufman, 1985).

Interactions of normal and delinquent families were compared and observed by Alexander (1973) and found that delinquent families appeared to have confusing interactions with unclear communications. He also observed that delinquent families were characterized by defensive communications, extensive dominance of talking time by one family member and a lack of communication focus. It was also seen that in these families, what a member said was not necessarily related to what had been said by the previous speaker.

In his review of family interaction research, Jacob (1974) suggests five aspects of family interactions that are likely to differentiate the family
systems of delinquents from those of non-delinquents. Compared to normal families, delinquent families tend to:

a. have more frequent parental disagreements during interactions and present conflicting directions to the children.

b. exhibit less differentiation between influence of parent and child on family decisions, with families of delinquents having equilibrium or child-skewed power distributions (inverted hierarchies) and non-delinquent families having hierarchial power distributions with parents more influential than children.

c. express less positive affect and more negative affect.

d. misperceive a greater proportion of communication.

e. present a larger proportion of communications that indicate an unwillingness to compromise.

Based on the observations of family interactions Minuchin (1974) concluded that delinquent families functioned less co-operatively and productively as a system than did non-delinquent families. Mothers of delinquents frequently relied on behaviour control statements (for e.g. telling the children to stop problematic behaviour), while parents from normal families were seen using directions that specified how the problematic behaviours were inappropriate and providing instructions about a more appropriate way to act.
While comparing interactions and communication styles of delinquent and adaptive families, qualitatively and quantitatively, Alexander (1974) noted three significant differences:

1. Talking time among families of delinquents was unevenly distributed, with one family member dominating talk during family interactions. In adaptive families, a more even distribution of talking time occurred.

2. Conversations in delinquent families were disjointed and disorganized. Whereas, conversation of adaptive families were focused upon a mutual topic, with the flow of conversation smooth and coordinated.

3. The context of familial conversations differed from the two types of families. Adaptive families had a greater proportion of supportive communications while delinquent families had a greater proportion of defensive communications. Roles within the delinquent families were seen to be less differentiated and parental directives less effective.

After an extensive review of the studies on drug use and family, Klagsbrun and Donald (1978) conclude that family interaction processes contribute to the maintenance of individual substance abuse.

8. Studies On Family Therapy With Addicts

The most promising, non-pharmacologic intervention that has evolved in the past decade for the treatment of drug dependence is Family therapy (Kaufman 1986). In his article "A workable system of family
therapy for Drug Dependence" Kaufman (1986) states four basic aspects on which family therapy can be developed into a workable system:

1. an understanding of the common family systems and patterns seen in the patients with drug dependence;
2. developing a system to establish and maintain a drug-free state;
3. a workable system of family therapy;
4. coping with family readjustment after the cessation of substance abuse.

According to Ackerman (1958) the criteria for emotional illness and health must not and cannot be restricted to the individual; they must include the individual within the group and the group as well. He further states that family and society are a continuum. The theoretical formulations on the individual psychopathology of the addict have been difficult to put into clinically successful practices.

Smith and Gay (1971) while discussing Schizophrenic and non-Schizophrenic heroin addicts state that both heroin addict populations have similar pathological family backgrounds and that they suffer from a serious deteriorating self-esteem. More studies on families and drug addicts have been conducted and are helpful in throwing light on this matter. Healy and Bronner (1936) state that anti-social children identified themselves with gross ethical distortions of their parents. In their study Johnsons and Szurek (1954) found that parents unconsciously condone the amoral or anti-social behaviour of the child who becomes a vehicle for the parents own anti-social impulses. The child is now in a position to blackmail.
the parents in terms of overt discipline, because of the gratification the parents get due to their child's anti-social behaviour. Gerard and Kornetsky (1957) state that the relations between the parents of adolescent addicts are poor and grossly disturbed. Also, their studies reveal that there is a strong familial need for high attainment, demanding that the child meet the family's high levels of aspiration and expectations. In his paper on moral masochism, Bronberg (1955) feels that the mothers of addicts have a great need to control and that they unconsciously identify the child with one of their own parents or siblings.

In an addict's family there is "the addictogenic relationship", where the addictor finds relief from his own emotional stress and tensions, by encouraging and/or perpetuating, unconsciously, the addiction. The pathological family relationship that is seen in the drug addicts' relationship with a significant member has etiological significance (Little and Pearson, 1966). It is also found that parents of drug users are intimately involved in their children's psychopathology (Hirsch, 1971). Another study on masochism (Berliner, 1958) states that there is a key interactional dynamic, in that the young child misidentifies parental criticism, hostility and maltreatment as a form of pleasure and for the rest of his life constantly re-enacts the original distortion. He libidinizes and introjects suffering, and the trauma thus becomes ego-syntonic.

Much of the research on family therapy has been carried out with schizophrenic persons and their families. However, the principles and theoretical framework can also be applied to families with drug addicts. One of the aspects that leads an addict to drug addiction, according to Framo (1970), is a "reciprocal interlocking of a multi-personal motivational
system not only in terms of etiology, maintenance and reduction of psycho-pathology, but in the individual members and between the members". Carek, Hendrickson and Holmes (1961) who worked with hospitalized adolescents whose parents consciously and unconsciously sanction delinquency, are of the opinion that the interaction between children and parents is characterized by an unconscious mutual manipulation between parent and child. These authors do not treat the entire family system as a unit. Rather, they separate the parents and the child in their treatment.

Ackerman (1956) has stated, that individuals as the unit of diagnosis is to be replaced by family group as the unit of diagnosis, therapy and prevention. Hirsch and Imhof (1975) conclude, from their evaluation of 47 families of the drug addicts who came to the Drug Treatment and Education Centre of North Shore University Hospital, that family therapy is the answer to the problem of drug addiction. They also feel that the family approach to drug addiction has merit and viability as a treatment modality.

Many family therapy evaluations in the fields of drug addiction have been carried out. Silver, Panepinto, Arnon and Swaine (1975) who have evaluated family therapy in this field, describe a methadone programme for pregnant addicts and their addicted spouses. In this programme 40% of the women became drug-free in treatment and the male employment rate increased from 10% to 55%. This study lacked follow-up data and control groups. The most outstanding study in this field is that of Stanton and Todd (1982) with hard core drug addicts. They made a comparison between paid family therapy, unpaid family therapy, paid family ‘movie treatment’ and non family treatment. A one year post treatment follow-up
was made and it was found that the two family therapy treatments produced much better results than non-family treatments in abstinence from drugs. The non-family treatment and movie groups did not differ from each other. A one year follow-up by Hendrick (1971) of narcotic addicts who had received 5.5 month of multiple family therapy (MFT), showed that they were twice as likely to remain in continuous therapy than addicts not responding to MFT. Kaufman’s (1977) work shows that adolescent addicts with MFT have half the recidivism rate of clients without it. Out of 68 studies of the efficacy of the family therapy of drug abuse, only 14 quantify their outcome. Only six of these provided comparative data with other modes of treatment or control groups (Stanton 1980).


Wermuth and Scheidt (1986) describe a model to enlist family support in drug treatment, in which Stanton and Todds principles of recruiting for family therapy generally apply. They put forth the idea of involving only one family member in multi-family groups and providing psycho-educational training rather than therapy.

Kaufmann (1980) stresses the importance of treating the adolescent substance abuser with the context of the family. She says that therapeutic community should be seen as an extension of home and home as an extension of therapeutic community. The help rendered to the family should be concrete and immediate. The overall goal in the model suggested
by Kaufmann is to restructure the family in such a way that each individual has a chance for optimal development within the family.

The most important causes for the growing number of addicts are societal involving community and familial dysfunction (Kaufman and Kaufmann 1980). Siblings are of crucial importance either through their addiction, which is enmeshed with that of the identified patient, or in their role as a parental, or an authoritarian child, or as a success with which the potential addict cannot compete.

Stanton and Todd (1980) suggest a structural family therapy with drug addict. The therapy is carried out in three phases. The initial phase, in which the addict and family is contacted, the focus is on setting common goals for treatment, forming an alliance with both parents. In the middle phase of the therapy changes start to occur and in the final phase, the addict may stop his drug taking habit.

MFT (Multiple Family Therapy) is preferable to work with families who are isolated or whose system is circulatory and rigidified. (Leichter and Schulman, 1974). They further note that this therapy provides a particularly fertile ground for those spontaneous and unexpected attitudes and insights to emerge, which occur almost as a by-product of ongoing process.

According to Papp(1974) hopeless families do better in groups. Berger and Bartlett have used MFTS with addict families. Berger (1973) focuses on patterns which contribute to self-rate and hurting oneself by hurting one’s parents. Non-verbal behaviours of members are also emphasized. Berger’s model also focuses on ‘crisis creators’ ‘help rejecting
complainers', preachers and placaters. He uses a small family group within the larger group. Hendricks (1971), in his study compared a group of male narcotic addicts who received multi-family counselling with a group which did not. One year after release, it was found that 41% of the treatment group remained in outpatient status compared to 21% of all male parents.

Drug addiction is a symptom of family stress that is exacerbated by societal stress (Kaufman and Kaufmann, 1980). A family crisis may occur. The focus during this phase is manifold. Crisis is to be resolved. Other problems related to drugs too are to be resolved. The family is given the charge of the detoxification process in the home and the therapist’s role is to have the family help the addict detoxify "cold turkey".

In the final phase the family is helped to plan their future lives, deal with parents’ marriage. When adequate charge has occurred and is maintained long enough for the family to feel a sense of real accomplishment, then, termination occurs. There has to be follow up sessions two or four months after termination.

Kaufman and Kaufmann (1980) suggest a multiple family therapy with drug abusers. This model was initiated by Laqueur (1971). Kaufman and Kaufmann improvised this modality to include social network intervention, multiple impact therapy, the ward or town meeting concept of both the psychiatric and synanon modes of the therapeutic community. They also use a lot of group and family therapy techniques in which psychodrama,
existential gestalt and encounter are used in group therapy and sculpting or choreography, structural and systems in family therapy.

Levinson, in his book 'The Addict and the Family' says that the family's first impulse is to do something when it discovers the presence of an addict member. But it does not know what exactly to do. In order to work through the problem of addiction, the family requires to follow certain strategies. From his experience with the families of drug addicts, he suggests some strategies for the family with a drug addict.

1. **Being cruel to be kind:**

   To evict or not to evict: The family must prohibit drugs and intoxication in the house. Once this rule is broken, the addict must leave, which means that money is not easily available to buy drugs. This helps the family to escape from the daily chaos and to get on with their own life. Also, it increases the addict's respect for the rule maker.

2. **Making use of guilt and anger:**

   Parents, siblings and partners have to realistically assess what they feel guilty about. By pinpointing the guilt, they can dispel the guilt by taking actions to rectify their mistakes. Anger fuels efforts to gain control over the drug user and the drugs. But this control is illusory. Instead of trying to protect the user, he or she must be held responsible for their actions. They must not be "let off the hook" by the family members.
3. Rescue from shame:

The family should not isolate themselves from outsiders, for, this only exacerbates emotional pain. Instead of losing sight of priorities by shutting themselves up, they should stay on course by talking to someone outside the family circle. This someone can be a social worker, a close friend, a self-help group, a psychologist or any counsellor.

4. Finding a sympathetic ear: The professional counsellor:

The family should approach a counsellor for professional help which will help them to understand the situation as well as ventilate pent-up feelings.

5. Prevention: A strategy for the next generation:

The family should take up steps to prevent drug addiction in the next generation. Children should be taught to respect their bodies, should be educated about health and nutrition and also on what medicine and liquid to take and to keep away from.

All these strategies require perseverance, according to Levinson. He says, sometimes the family has to simply stand firm on a decision or make a commitment to try. Some of the strategies mesh with each other and overlap and therefore they can be used simultaneously. With a ring of consolation, Levinson states that it is only natural that the family members will be frustrated at first. No deliberate move will be easy when family members are distraught and hurting. Patience, he says, is the by-word.
Summary

Many factors have been found to increase the probability of drug abuse like early cigarette use, psychological disturbances such as depression, low academic motivation (Smith and Fogg, 1978) other problem behaviours (O’Donnell and Clayton, 1979), high experience seeking (Zuckerman, et al. 1979); high family misuse of substance use (Kandel et al. 1979); peer influence during adolescent (Elliot, 1982).

Robins (1978) has found that although ecological relationships may exist, socio-economic status and ethnicity do not appear to be major sources of severe anti-social and drug abusing behaviour. The literature on the efforts of race and ethnicity, socio-economic status and family structure on substance abuse, generally is unsupportive, contradictory or inconclusive (Gersick, et al. 1981); (Kandel, 1982); and (Loeber and Dishion, 1983).

According to Kandel (1982), socio-demographic factors have little predictive power. Gersick and others (1981) suggest that the research evidence supports a move away from a focus on socio-demographic factors to a move towards integrative theories of socio-contexts and interpersonal transactions.

Wynne (1969) says that from the stand point of the etiology and pathogenesis of psychiatric disorders as well as their treatment and presentation, the family is commonly regarded as a primary setting in which both the normal process as well as psychological disorders arise. Thus it can be seen that family studies have progressed from simplistic
clinical descriptions of psychopathology in family members to a concentration on pathological relationships that are constituted by the family milieu, including its communication patterns. The focus on family, therefore, should be both for determining etiology and to implement treatment and preventive plans.

It has been confirmed through this review of family based research focused specifically on drug abuse, that, familial factors influence the onset of drug abuse. It is with this in mind that the researcher selected this area of study. In this work the researcher wishes to study family functioning of the drug addicts using the model suggested by Bloom (1985) to measure the level of functioning of the families. The scale is titled "Family Functioning Scale" and incorporate fifteen variables such as Cohesion, Expressiveness, Conflict, Intellectual-Cultural Orientation, Active-Recreational Orientation, Religious Emphasis, Organization, Family Sociability, External Locus of Control, Family Idealization, Disengagement, Democratic Family Style, Laissez-faire Family Style, Authoritarian Family Style and Enmeshment. The researcher also wishes to inquire the level of Social Support System enjoyed by the families of drug addicts.

The relationship between the above variables and drug addiction has been explored by earlier researchers. Some of the important among them are reviewed below. Very little closeness or cohesion has been found to exist between the drug users and their parents (Kaplan, Meyerowitz, 1970; Strei and Oliver, 1972; Tolone Dermott, 1975; Barnes, 1977) and between their parents (Levin 1972). Sedlin (1972), Blum et al. (1972), Cannon (1976) have found that such conditions as drug addiction produced only very little cohesion in a family. The most affected area in the
family under stressful situations is the ability to communicate effectively (Bron, 1975; Sorosiak et al. 1976). Due to blocked communication, the members are unable to express themselves, and cries for help are seldom heard (Reilly 1975). Due to lack of family closeness, there is a lack of affection and rejection and hostility (conflict) (Remner, 1962; Streit et al. 1974; Alexander and Dibb, 1977; Barnes, 1977). Due to little cohesion in the family very few messages of value and inclusion are transmitted to family members (Sedline, 1972; Chetin et al. 1964; Blum et al. 1972; Cannon, 1976). The values may be intellectually or recreationally or religiously oriented.

Those families who stay intact have been found to suffer serious disruptions (Amark, 1951; Chetin, 1964; Graig and Brown, 1975). Most of these families are disharmonious, unhappy and undirected (Blum et al. 1970; Bahnson, 1972) (organization). Sedlin (1972) found that parents are often immature and unable to adapt to changing situations (Pittman and Gordon, 1958) thus providing a poor social context for social skills (Sociability).

Rona Sinelain, a former drug and alcohol counsellor says that the family and the drug abuser use defense mechanism like blaming someone or something else, or power beyond for the drug problem (External locus of control).

Due to parental rejection and hostility, drug users are dissatisfied with their families, finding them less enjoyable (Tec, 1974). This reflects on their family idealization. Thus the family loses its salience for the user, producing vacuum in the user's life (Tec.1974). Therefore, the drug user
seeks fulfillment from friends and becomes very peer-oriented (Kandel, 1975; Dembo et al. 1976; Kandel et al. 1976), which means they move away from their family. Friedman et al. (1987) have found families of drug abusers to be disengaged.

Discipline problems have been found in the families of drug users (Blum et al. 1972; Jenson, 1972; Lewis, 1972). It has been found by researchers that families that used Democratic discipline, where rules are discussed in advance, joint-decision is made by parents and their children, produced fewer adolescents who used drugs than did parents using other types of discipline (Thomas and Weigert, 1971; Cannon, 1976; and Blum et al. 1972). Laissez-faire discipline, where children set up their own rules and limits, rules and standards are poorly defined, has been reported in most of the families with addict members (Reilly, 1975; Barnes, 1977; Amini et al. 1976). Strong correlation has been found between authoritarian discipline and drug abuse (Hangen, 1970; Corss and Davis, 1973; Miller, 1974). The literature on families of drug users/abusers suggests that there is a lack of clear inter-generational boundaries and that some of the families tend to be excessively cohesive or enmeshed (Brook, 1978; Kaufman and Kaufmann, 1979).

Miller (1974); Cannon (1976) have found that families of drug users exhibited a lack of love and its members got little support from the family (Jensen, 1973; Cooper and Olson, 1977).

The researcher finds through this review that cohesion, expressiveness, conflict, intellectual-cultural orientation, active-recreational orientation and religious emphasis, organization, family sociability, external
locus of control, family idealization, disengagement, democratic family style, authoritarian family style, enmeshment and social support to be playing a role in the contribution, perpetuation or maintenance of drug use and also these variables are found to be affected by the presence of addict in the family.

The researcher wishes to study in detail the 16 variables mentioned above as he considers these variables to be very important in the study of family of drug addicts. The family functioning scale developed at Colorado University was used. Since 15 of these variables are studied by the scale, the researcher developed a scale in order to study the remaining variable, that is, social support.