CHAPTER I
INTRODUCTION

Drug usage is not a new phenomena. It has a history of nearly ten thousand years and was prevalent almost in all civilizations. Poppy was known to man in prehistoric times. Opiates have been in use for at least 8000 years for its pain relieving properties. In Sumerian civilization, Persia, Egypt, Greek and Rome cultures opium was used in medicine and religious rituals. Arabs were probably the first ones who started using opium systematically as a psychoactive substance. Arab traders spread opium habit and cultivation of poppy to Persia, India and China and introduced it to European doctors. In India also, the use of psychotropic drugs has a history and mythology of thousands of years. Soma and Sura were two famed celestial drinks, origin of which is attributed to mythological ‘Sagar Manthan’. Use of Cannabis Indica, the Indian hemp, has been continued in India all through the ages. This all shows that alcoholic drinks, cannabis and its derivates and opium have been in use since long with wide socio-cultural and religious acceptance. But abuse of drugs is the disorder of the so called modern technological society because drugs serve as the auxiliaries for coping with recurrent psychological stress of modern living. Natural drugs such as cannabis, cocaine, poppy, opium and khat which were previously used within certain cultural settings and confined to traditional ways of life have been increasingly exploited and have now reached an epidemic level. Synthetically manufactured drugs such as amphetamines, barbiturates and wide range of sedatives and tranquillizers have become more readily available in market. One of the most important changes which have been noticed is that earlier drug use was limited to adult population only but now all types of drugs are in use by almost all categories of people viz. pre-adolescents, adolescents and post adolescents (Smith, 1989). And these too are not confined to any given sex, class or socio-economic conditions. Even though addicts tend to give various reasons and justifications for their drug usage, most notable among them have been enjoyment, to get high kick, to satisfy curiosity, to relieve tension, psychological pressure, company of friends, to remove fatigue, to feel relaxation and peace and to get...
proper sleep. Opium derivative addicts invariably reported increased work efficiency as one important reason for using the drug. In high percentage of addicts, curiosity to examine the effect of drugs as a sexual stimulant was found as major contributory factor.

The search for pleasure or to remain under the influence of ‘nasha’ may not be a search of pleasure for pleasure sake only but to overcome mental tensions caused by frustrations and shocks of everyday life suffered both in and outside the home. Scientific evidence shows that intoxicants by themselves do not sponge-off tension and fatigue. On the contrary non-medical use of drugs interferes with the body and brain functions, and inhibits psychomotor abilities. For instance, alcohol affects liver and brain; amphetamines cause insomnia and lack of appetite; barbiturates give rise to muscle convulsions and tremors; cocaine weakens muscles; LSD produces delusions which may result in suicidal tendencies. It has been a very common practice in all ancient cultures and religions that people tend to associate the use of specific substances with certain rituals, legends, myths and misconceptions. But it is important to note that supposed achievements associated with various drugs portrayed by myths and legends are unfounded mere exaggerations and without any scientific support. On the whole, each and every myth associated with psychotropic drugs has been explored time and again by many researchers (Modi & Modi, 1997; Khan, 1985; Kapoor, 1985; Wilson, 1973; Krystal & Raskin, 1970; Lingman, 1969; Deropp, 1958).

In order to understand the phenomena of drug dependence various definitions and various theories were proposed which elude consensus. Attempts at a unified theory of drug addiction have also not been successful. Part of the problem can be attributed to substantial disagreement over the issue of definition of addiction itself. While those adopting habit forming or reinforcing view prefer to identify addiction with compulsive drug self administration (Jaffe, 1985), others tend to link addiction to physiological dependence syndrome (Edward et al., 1981). However ‘World Health Organization’ has adopted the following definitions and usages for the dependence producing drugs that “any substance that when taken into the living organism may modify one or more of its functions would be called a
Drug dependence is a state of periodic or chronic intoxication detrimental to the individual and to the society produced by the repeated consumption of a substance (natural or synthetic). Its characteristics include (a) an overpowering desire or need to continue taking the substance in order to experience its psychic effects and sometimes to avoid the discomfort of its absence and to obtain it by any means, (b) a tendency to increase the dose and (c) a psychic and sometimes a physical dependence on the effects of substance.

Addictive behaviours i.e. behaviour based on the pathological need for a substance may involve the abuse of substances. The repeated misuse of drugs may take the form of dependence. In traditional parlance, dependence signified psychological reliance on a particular drug, while addiction was reserved for physiological dependence, as indicated by withdrawal symptoms if the drug was to be discontinued. Recently however, drug dependence has come to denote both psychological and physiological dependence. The term drug abuse is used to indicate the excessive consumption of a drug, regardless of whether an individual is truly dependent on it. Of course, drug abuse often leads to drug dependence. "Drug abuse is defined as taking a drug for reasons other than medical, in an amount, strength, frequent or manner that damages the physical or mental functioning". The term itself conveys the notion of social disapproval and usually by self-administration of any drug in a manner that deviates from the approved medical or social patterns within. Drug abuse is growing at an explosive rate in just little over a decade and has spread its malevolent tentacles to almost every part of the globe surmounting almost all barriers of race, caste, creed, religion, sex, educational status, economic strata, etc., with astounding ease. Increasing evidence is pouring in to suggest that a large percentage of students are being hooked on dependence-producing drugs and have succumbed to the illusory panacea of drugs (Arneja & Sen, 1990; Jiloha & Manjal, 1985). Addictive behaviour is one of the most pervasive and intransigent mental health problems facing our society today (Grant et al., 1994; Kessler et al., 1994).

The need for increased amount of substance to achieve the desired effects in case of diminished responses to the same quantity of a drug is called tolerance.
When the repeated use of a drug results in a tolerance not only for that drug but for other drugs or the same of related type, it is called 'cross tolerance'.

The repeated abuse of any substance among youth is resulting in their tolerance for multiple drugs even. The degree of tolerance and the rate at which it is acquired depends on the specific drug, and the frequency and magnitude of its usage. The mechanisms by which physiological tolerance for various drugs is acquired are not fully understood. There is some evidence that it develops at the level of central nervous system. In addition, learning also plays an important role in changing an individual's attitude towards the drug and his response to it after repeated use. In spite of well documented adverse physiological and psychological effects of psychotropic drugs, the problem of drug abuse has not only persisted but is also gaining grounds in its various ramifications and extending its domain and frontier to hitherto unknown territory of human life with every passing day.

The consequences of drug addiction are multifarious and ought to be understood in their entirety. Financial condition of drug addict is weakened to such an extent that they have to suffer hardships. They are ignored by the community because of their being addicts thus they feel alienated in society. Impact on their employment is also very obvious. It is beyond doubt that drug addict himself has to undergo and suffer the major consequences of his addiction, yet it must be kept in mind that the addict being a part of family, community and society leaves a scar on all these social units. Everyone whosoever with he interacts like his family members in various categories - parents, siblings, spouse, children or other relatives, friends, colleagues and neighbours, all have to bear the impact of his addiction to drugs.

COMMONLY ABUSED SUBSTANCES

The most commonly abused substances which result in various kinds of substance related disorders have been identified in DSM IV classification system as alcohol, amphetamine, caffeine, cannabis, cocaine, hallucinogen, inhalant, nicotine, opioid, phenylcyclidine, sedative and polysubstances. Another way of classifying drugs can be on the basis of the effects a drug category have on the user. Following this perspective a brief overview of substance classification is given below.
Narcotics (Opium and Its Derivatives)

This class of drugs includes opium and its derivatives such as heroin and morphine. Opium is extracted from the plant *Papaver somniferum*. The main active ingredient is alkaloid morphine. Opioids, meaning opiate-like, are derivatives of opium. All opioids can produce euphoria and can be used as analgesics. Opium and its derivatives like morphine and heroin produce euphoria, drowsiness, reverie, and sometimes a lack of coordination. Their reputation as an analgesic (pain killer) gave these a medicinal status throughout centuries. Opioids are the most powerful known pain relievers. Their use and abuse date back to antiquity. Opioids have been used for at least 3,500 years. For most of that time, they were used in the form of crude opium or in alcoholic solutions of opium (containing morphine and codeine). Morphine was first isolated in 1806, and codeine was isolated in 1932. Over the next century, the pure drugs morphine and codeine gradually replaced crude opium for medicinal purposes, although non-medical use of opium (as for smoking) still persists in some parts of the world. The first semisynthetic derivative- diacetylmorphine or heroin- was introduced into medicine in 1898. The first purely synthetic opioids, meperidine (Demerol) and methadone (Dolophine), were introduced into medical practice in the 1940s. Opioid dependence, or at least opioid withdrawal, was first recognized in 1700. Although opioid dependence was common by the middle of the 19th century, it was not until later in the century that it came to be seen as an important medical problem. The emergence of more severe forms of dependence associated with the newly introduced hypodermic needle and syringe, and a growing awareness of the problem of allowing opioids to be sold in over-the-counter patent medicines and to be casually dispensed by practitioner with minimal training generated media attention and public debate. The debate, combined with international considerations, led to legislation at the state and federal levels that restricted opioid use to medically recognized purposes and required a legitimate prescription for most use. In the United States the Harrison Act of 1914 had a profound influence on those who were already addicted. The new law was interpreted as excluding the provision of opioids to addicts.
as a legitimate medical use. Clinics that had been established to provide morphine to addicts were closed, the last in 1923. Doctors were encouraged to avoid opioid addicts entirely. Treatment efforts were a disappointment to both physicians and patients: relapse after detoxification was typical. An illicit traffic arose that provided access to opioids (mostly morphine and heroin) to persons who no longer could use medical channels to get their drugs. Although increasingly harsh penalties for the sale or possession of opioids were enacted, heroin addiction persisted and its prevalence rose following World War II. By the early 1960s some thoughtful observers recommended remedicalizing heroin distribution as a way to reduce crime associated with heroin addiction.

Opioids can be classified as naturally occurring opium derivatives – Morphine; partially synthetic derivatives of morphine - Heroin, oxycodone, oxymorphone; synthetic compounds - Fentanyl, alfentanil, levorphanol, meperidine, methadone, codeine, propoxyphene. Although there are more than 20 chemically distinct opioid drugs in clinical use, the most prevalent problems are associated with heroin, a drug that is not used for therapeutic purposes in the United States. Dependence on other opioids is limited largely to persons who have developed dependence in the course of medical treatment or to health care professionals who have access to opioids. However, the patterns of opioid use and some aspects of toxicity are powerfully influenced by the route of administration and the metabolism of the specific opioid, as well as by the social conditions that determine its costs and purity and the sanctions attached to its use for non-medical purposes.

The term narcotic means drugs producing narcosis or sleep. Although narcotics do produce sleep, the term does not indicate their major therapeutic use today. Heroin has an additional initial effect the 'rush' a feeling of warm, suffusing ecstasy immediately following an injection. The addict sheds worries and fears temporarily and has great self-confidence for four to six hours and then let down, bordering or stupor. Heroin is used in nearly all forms in India. There are states that permit the use of heroin as culturally sanctioned phenomena. There are other states like Nagaland and Manipur where HIV is on the rise and 80.9% of the drug abusers
are injectable drug abusers (Kumar et al., 1996). Many Indian patients differ from patients in other parts of Asia with the presence of an increased family support. As these drugs are central nervous system depressants, these relieve pain. All these are clearly addictive in the physiological sense, for users show both increased tolerance of the drug and withdrawal reactions when they are unable to obtain another dose.

**Stimulants (Amphetamines)**

Known as 'uppers' or 'psychological energizers' are drugs which facilitate or increase synoptic transmission and thereby usually make one physically and mentally more active. This class of synthetic stimulants includes benzedrine, dextroamphetamine, methedrine, methaqualone, and pep pills. They produce increased alertness, wakefulness, euphoria, and even exhilaration. Other effects amphetamines produce are similar to those of norepinephrine in the sympathetic nervous system. They are taken orally or intravenously and can be addicting. Tolerance for this class of drugs develops rapidly. Wakefulness is heightened, intestinal functions are inhibited, and appetite is reduced - hence they are used in dieting. The heart rate is increased and blood vessels in the skin and mucous membranes constrict. The individual becomes alert, euphoric and more outgoing and is possessed with seemingly boundless energy and self confidence. Larger doses can make the person nervous, agitated, and confused, subjecting him or her to palpitations, headaches, dizziness, and sleeplessness. Sometimes the high level user becomes so suspicious and hostile that he or she can be dangerous to others. There are some reports that large doses taken over a period of time induce a state quite similar to paranoid schizophrenia, including its delusions. This state can persist beyond the time till the drug is present in the body. Intense euphoric activity is maintained for a few days without eating and sleeping after which they are exhausted, depressed and sleep for several days. Then the cycle sets in again. Frequent ingestion of large amounts of amphetamines is also believed to cause brain damage.
Sedatives (Barbiturates)

This class of synthetic chemicals was introduced in 1930s and is considered extremely dangerous resulting in quick physiological and psychological dependence. Two types of barbiturates have been distinguished as long acting for producing prolonged sedation and acting for prompt sedation and sleep. The short acting barbiturates are usually viewed as addicting. These are known by such names as Nembutal, Seconal, Veronal, Tuinal, Luminal and Amytal. The main effect of barbiturates is to reduce anxiety, slow body functions, produce relaxation and eventually bring drowsiness and sleep. The feelings induced by these drugs are somewhat similar to those associated with alcohol usage. At low dose level they produce relaxation, a feeling of well being and a decrease in attentiveness. Excessive doses cause speech tremors and occasionally cause death. Barbiturates increases parasympathetic activity and act as downers. The slow beating of the heart take blood away from the surface of the body, retard the rate of breathing and thus the user find it difficult to react quickly to any emergency.

Abrupt withdrawal of barbiturates cause severe and potentially lethal withdrawal symptoms like increase in anxiety, restlessness, sweating, shakiness and insomnia followed by hallucinations, confusion and delirium (Lather, 1993).

Psychedelics and Hallucinogens

The hallucinogens are drugs whose properties are thought to induce hallucinations. In fact, these preparations do not so often 'create' sensory images as much they distort them so that an individual sees or hears things in different and unusual ways. These drugs are often referred to as psychedelics. There drugs range from the naturally occurring variants such as peyote, psilocybin, and amanita muscaria to laboratory synthesized substances such as 'lysergic-acid-diethylamide' (L.S.D.). These drugs are also called psychotomimetic drugs as they mimic the psychosis like symptoms. Marijuana or bhang produced from cannabis sativa is the most commonly used drug in this category and the most controversial too. It is classified as one of the milder hallucinogenic drugs because of its effect. The reactive ingredient in it is a complex chemical known as delta -9-
Transtetrahydrocannabinol (THC) also called hashish or hash. The drug is not physically addictive but its user can become psychologically dependent. Marijuana, Charas or Bhang are used mostly for leisure and pleasure. These alter the mood and perceptions. The user feels euphoric, expansive, has a tendency to talk and laugh with bouts of hilarity. User experience well-being and loss of inhibitions, time seems to pass slowly and there is distorted perception of space, distance and shapes. Hallucinogens cause fall in pulse and heart rate, impaired co-ordination, loss of balance and inability to concentrate. It weakens short term memory, logical sequence of thinking, motor skills and decreased ability to perform complex tasks. With prolonged use person becomes nervous, irritable, short tempered, anxious and depressed. Chronic heavy use can cause bronchitis, respiratory diseases, cancer of the lung and head-neck region. There is diminished sexual drive and infertility. It can cause brain damage also.

**Alcohol**

Alcohol is a mixture of water and ethyl alcohol (ethanol) and is prepared by fermentation of fruits, vegetables or grains or by a process of distillation. For abundance of calories and lack of proteins and vitamins in alcohol even moderate drinkers may be pot bellied and overweight yet, they suffer from nutritional deficiencies. Alcoholism develops slowly and it may take years before the person himself or his family and friends realize that a problem exists.

Alcohol is a depressant that affect the higher brain centers, impairing judgment and other rational processes and lowering self-control. Some degree of motor in-co-ordination soon becomes apparent, and the drinker's discrimination and perceptions of cold, pain and other discomforts are dulled. Typically the drinker experiences a sense of warmth, expansiveness, and well-being. In such a mood state, unpleasant realities are screened out and the drinker's feelings of self-esteem and adequacy rise temporarily. An investigation by Sayette (1994) showed that when intoxicated people describe themselves, they are more likely to present negative attributes in a manner that is isolated from self-concept than sober objects. Alcoholic neglects his personal appearance and having lost his self-esteem, feels
little remorse about any aspect of his behaviour and he ceases to care at all about family and home, about friends, occupation, and social status.

Physiological changes include damage to endocrine glands and pancreas, heart failure, hypertension and capillary hemorrhages, which are responsible for the swelling and redness in the face, and especially of the nose of chronic alcoholics and liver cirrhosis and damage of brain cells especially in frontal lobes and cortical atrophy, are some of the physiological consequences of prolonged alcohol use.

**Tobacco**

Tobacco is obtained from the dried leaves of a number of species of plants belonging to the nicotine family. The active ingredient of tobacco leaves is nicotine alkaloid. Pure nicotine is a clear oily liquid which has a series of complex effects on brain activity - primarily as a stimulant. Tobacco leaves contain tar and nicotine and when burnt, release carbon monoxide and other gases, when smoked, nicotine is absorbed by the lungs. Nicotine is used by smokers to maintain performance in the face of fatigue and monotony. Regular smokers claim that it alleviates stress and anxiety. On inhaling, smoking has an immediate effect which rapidly declines, thus encouraging the smoker to increase the frequency while in a novice, one or two cigarettes cause arousal, and a habitual smoker feels stimulated and relaxed at the same time and experiences great satisfaction on inhaling. Smoking can do untold damage to the body in terms of diseases of lungs and throat like respiratory problems, chronic cough, bronchitis and pneumonia and cancer even. It is directly responsible for blood clots and poor circulation leading to heart diseases-heart attack, strokes and gangrene of feet and lungs.

**THE ISSUES OF CAUSATION OF SUBSTANCE ABUSE/ADDICTION**

No single causal pattern fits well for abuse and addictions to different kinds of substances. Fulmer and Lapidus (1980) concluded that the most frequently cited reasons for beginning the use of drugs were pleasure, curiosity and peer pressure. Other reasons such as life stress, personal maladjustment, and socio-cultural condition also play their part in the onset of drug abuse (Bry, McKeon & Pandina,
Some researchers have regarded the physiological changes in the body affected by drugs as the most important factor in drug addiction. Because physiology of the body has been changed by the drug, it reacts when the substance to which it has become accustomed, is no longer administered. These disturbances, i.e. withdrawal or abstinence syndromes are made up of specific array or symptoms and signs of psychic and physical nature that are peculiar for each drug type. These conditions are relieved by re-administration of the same drug or of another drug of similar pharmacological action within the same generic type. No overt manifestation of physical dependence is evident if an adequate dosage is maintained. However the process of craving for different substances has been viewed differently by different researchers. For example ‘genetic vulnerability’ for extreme craving for alcohol has been advocated by some researchers (Dawson, Harford & Grant, 1992; Cloninger et al., 1986; Cotton, 1979; Goldstein, A., 1974; Pert & Synder, 1973). Bolles & Fanselow (1982) identified specific receptor sites for narcotic drugs in brain. Similarly physiological processes involved in dependence on stimulant substances have been somewhat different but specific in terms of neurological states (Kleinmen et al., 1992; O’Malley et al., 1992; Gawin & Kleber, 1986). Marijuana and other Hallucinogenic drugs however have little physiological basis for its abuse. Some investigators suspected that endorphins may play a role in drug addiction but research in this regard has been inconclusive. Many researchers however questioned this trend of reducing the drug dependence problem to just physiological factors (Chassin et al., 1993; Vega et al., 1993; Schaefer, 1977, 1978). Many researchers have advocated the investigation of other reasons like life stress, personal maladjustment and socio-cultural conditions (Harford & Parker, 1994; Morey, Skinner & Blashfield, 1984; Bry, Mckeon & Pandina, 1982)

‘Psychological theories’ of the origin of alcoholism and addiction usually emphasize reduction of distress, and pleasant feeling and euphoric state that drugs produce. These theories attempt to explain why particular kind of people seems to need these effects. Most psychoanalytic accounts of drug addiction points to fixation at the oral stage of development as precipitating cause. According to this point of view early mother-child interaction supposedly either frustrate dependency needs
during this stage of maturation or satisfy them to too great an extent. Other psychodynamic accounts examine and describe drinking or drug usage as a defense mechanism adopted to reduce stress caused by emotional conflict and eliminate guilt (Davison & Neale, 2001). Learning based accounts of drug addiction demonstrated that drug abuse and addiction is a learned response that is acquired and maintained because it reduces distress. Sher & Leveson (1982) suggest that people begin drinking to dampen tension. Hull (1981) proposed that drugs decrease self awareness by interfering with the cognitive processes that select information about the self, hence serve as means of coping with failure and negative thoughts about self. Cox & Klinger (1988) & Cooper (1994) presented a motivational model of drug usage, which places a great deal of responsibility on the individual i.e. a person decides, consciously and unconsciously whether to consume the drug or not to bring about affective changes. In recent years a number of investigators have been exploring the idea that cognitive expectancies might play an important role both in the initiation and maintenance of addictive behaviours of adolescents who began to use drugs (Connors, Maisto, & Derman, 1994; Stacy, Widaman, & Marlott, 1990).

Many researchers prefer to focus on cultural factors that play a part in determining the incidence of alcoholism and drug abuse in a given society e.g. the degree of stress and inner tensions produced by the culture provide substitute means of satisfaction and other ways of coping with tension and anxiety (Vega et al., 1993; Barry, 1982; Noble, 1979). Rapid social change and social disintegration also seem to foster drug usage.

**DRUG ABUSE AND PSYCHOPATHOLOGY**

In recent years substantial research has focused on the link between alcohol or drug abuse disorders and other psychopathological syndromes such as antisocial personality, depression and schizophrenia (Harford & Parker, 1994). Some researchers have suggested a distinctive character- organization in terms of ‘alcoholic personality’, characterized by emotional immaturity, over expectations from others, requiring inordinate amount of praise and appreciation, low frustration tolerance, impulsiveness and aggression (Sahasi et al., 1990) and inability to delay
gratification (Meyer & Mirin, 1979). Personal maladjustment appears to be most common background among all drug abusers though all maladjusted people do not become addict. The other most commonly diagnosed disorders among drug abusers were antisocial personality (Harford & Parker, 1994; Regier et al., 1993; Codoret, 1985); personality disorders (Kosten & Rounsaville, 1986); depression (Lutz & Snow, 1985; Weissman et al., 1977); schizophrenia (Buckley et al., 1994; Mueser, Yarold, & Bellack, 1992); borderline personality (Miller et al., 1993) and anxiety disorders (Himple & Hill, 1991). Despite reported close association between these psychopathologies and drugs addiction it can not be inferred that all individuals having above reported psychopathological syndromes become drug abusers/addicts. For whatever reason these co-occur, the presence of other mental disorders in alcohol/drug abuse patients is very important consideration when it comes to the treatment part (Franken & Hendriks, 1999). Messina, Wish, & Nemes (1999) in fact found that very troubled people showed virtually no improvement in any de-addiction treatment.

On the basis of available empirical evidence there has been a strong tendency among researchers to link the whole phenomena of drug abuse to either genetic predisposition or personality structure or personality disorders or to attribute it to social/cultural factors. But this has been an oversimplification of the issue. Moreover one of the most serious problems in search for causal factors responsible for drugs abuse is how to determine if the behaviour and personality factors being investigated are an antecedent to the substance abuse or caused by substance abuse itself.

**DRUG ABUSE AND AIDS**

These days AIDS is another most pervasive problem facing our society and a major health priority. In most AIDS infected cases drug abuse has been observed as very prevalent, in some cases as a causal factor and in others as a coping strategy to deal with their social isolation and psychological distress. Hence while addressing the problem of drug abuse another important issue of practical significance which can not be overlooked or neglected is the problem of AIDS. The issue pertains to interface between psychology and physical health which has added anxiety to our
already existing fears and threats regarding well-being of humans. Psychological consequences of AIDS for infected people are much more serious than just the deterioration of their immune system. Those who develop AIDS may find themselves isolated from social support network. Stress, emotional disturbances and other psychological disorders among AIDS patients are relatively common (Jainchill, Yagelka, Hawke, & DeLeon, 1999). Sexual contacts and needles used to inject drugs are main source of onset of AIDS. The only exception is recipients of infected blood transfusions or infants born to infected mothers.

According to an American estimate 79% of AIDS patients have been drug abusers. If use of marijuana is added to this figure it would be close to 100% use (Sinha, 1988). A number of reports of drug injectors have shown that a significant number of them had history of risky sexual behaviours. A significant proportion of women purchase drugs at the cost of their sex (Chowdhury et al., 1997).

Apart from survey reports of different countries presented by WHO (1993), research studies and surveys conducted in India have drawn attention to the possible link that exist between drug use and prostitutes (Hoffman, Klein, & Crosby, 2000; Chowdhury et al., 1997). A strong relationship between drugs, alcohol and promiscuity has been invariably reported in research literature. The way AIDS continues to accelerate geometrically in all developed as well as developing countries, for India the chances of this epidemic appear to be more destructive. In the absence of any effective treatment approach to this problem, researchers have been focusing on some preventive programmes. In this regard most research studies have shown that drug users have been a high risk group for the developing and spreading of AIDS. Data also suggest that drug users are aware of the risk but they engage in risky behaviours unmindful of consequences (Spirito et al., 2000; Rasch et al., 2000). Any successful intervention in spread of AIDS need to focus upon and check the drug abuse and addictive nature of behaviours itself which is the most difficult and challenging task before behavioural scientists.

Despite the meaningful and valuable contributions of various above discussed researchers to the understanding of the problem of substance abuse and addiction these researches have not been able to solve the riddle completely. In
fact, the complex dynamic interplay of certain factors seem to be the basis of one’s priorities and choice of substance use from amongst various other available alternatives at the same point of time. This is clear from the ambiguities implied in the findings of various above mentioned researchers as many people having similar personality characteristics or undergoing similar circumstances in the same socio-cultural milieu do not become addicts while others with dissimilar ones indulge in drugs. The complexity of the issue more prominently came to the fore when treatment part of substance abuse/addiction comes in. All efforts put in the cases bring very desirable results in some cases but in others these prove a total failure. It is need of the hour to investigate the issues involved in such differing outcomes for different individuals.

An individual’s first experience with alcohol or drug may be accidental one but one’s continuing in the drug menace and retreat from this death-well can not be considered as accidental though it might be so in some rare cases of substance abuse. Although some distinct personality make up of the individual certainly predisposes the person to drug risk but family is the most potent factor which sets the stage for onset of drug abuse as well as individual’s successful recovery after willful detoxification treatment. Stressful life events do serve as a precipitating factor in an individual’s personal maladjustment and anxiety which individual wish to cope with or escape via taking alcohol or drugs.

Most personality theorists tend to emphasize heavily the ‘person’ as a major factor in addictive behaviour as well as his retreat from this. This line of enquiry tend to account for many different issues like motivation (Desai, 1997; Cox & Klinger, 1988), sensation seeking (Basu et al., 1995; Virkkunen et al., 1994; Pedersen et al., 1989), meaningfulness in life (Newcomb & Harlow, 1986), emotional distress (Newcomb, Maddahian, Skager & Bentler, 1987), personality traits (Nathan, 1988; Cox, 1985; Cox & Loper, 1983) and self esteem (Kaplan, 1980) etc. Different psychologists emphasized different factors/aspects of personality in drug abuse. However, it is the individual person who is actually addicted. Focus on specific factors/aspects of person in drug abuse can not serve as criteria for differentiating individuals who are at high risk for substance abuse or not (Finn, 1990). Even
American Psychiatric Association (1998) considering drug addiction as symptomatic personality disorder emphasizes the individual who is addicted. While Rogers analyzed such problems in terms of fully functioning personality and the construct of self (Cox & Klinger, 1988), motivational model places a great deal of responsibility on the individual who decides consciously or unconsciously whether to consume alcohol or any other substance or not. Allport prefer to highlight the 'Proprium' and Maslow 'the Self', psychodynamic theorists prefer to focus on 'Ego' and its functions for analyzing an individual's position with regard to his decision making or choosing processes. In 'An outline of psychoanalysis' Freud attributed all rational controls to ego. Its primary task is self preservation. Ego development is the gradual acquisition of skills and techniques for achieving one's goals and for satisfying one's wishes within the boundary of demands of reality. Ego screens out the desirable and undesirable form what is available to awareness. Then it adapts to or modifies the external world to its own advantage via efficient problem solving strategies using reality testing mechanisms. Such a goal requires the person to learn, think, reason, perceive, decide, memorize and so on. Ego accordingly uses cognitive and perceptual strategies in its endeavor. At this point either it fails or takes refuge in mechanisms of defense to protect the individual from anxiety or neurosis or it successfully accomplishes the desired solutions. In such a state ties or cathexis between impulses and objects become mediated by it and ego successfully preserve the integrity of the person through establishing a suitable course of action. Such a state of ego would be called ego integration. All psychoanalytic theorists while dealing with any case of mental illness emphasize that it is the disturbance of ego that usually calls attention to the fact that something is wrong. If the ego can be restored to the normal functioning, the individual will be well again. Freud always handled neurosis as disorder of the ego and it is not to be wondered at that the ego, when it is weak, immature and incapable of resistance, should fail in dealing with problems which it could handle with utmost ease. Neo-Freudians (Freud A., 1946; Erikson, 1963) systematically extended Freud's concept of ego and depict the ego as an autonomous structure of personality that follows a course of social - adaptive development which parallel the development of id and the instincts. All
psychodynamic theorists believe that under normal conditions ego monopolizes the store of psychic energy and use it for growth promoting psychological purposes. But when for various reasons anticathexes of ego become stronger than cathexes, manifestation of various kinds of behavioral problems set in. Alcoholism and drug abuse is to be seen as just a special case of this problem. When the various theorists and researchers emphasize that drug abuse behaviour should be looked at as a disorder of the whole personality, it would make more sense if it is analysed in terms of states of the ego of the individual’s who indulge in drug abuse as well in his treatment part. Factor analytical investigations of Cattell (1965, 1979, 1982) and his followers provide strong empirical support to the existence of the construct of ego in personality as a general factor, which established the use of this construct in given empirical research as more valid. No empirical work is available in the area of drug addiction which focuses on ego factor of the addict.

In order to make the present investigation a wholistic and integrative account for understanding causation and effective long lasting treatment, variable of ego state in terms of ego integration was chosen for study. Some authors have tried to account for variables relating to the family such as parental attitudes, parent–child relationship, family size and history of drug abuse in the family (Lather, 1993). Conger (1977) had rightly remarked that one must look for profound disturbances in family relationships during development of the child for understanding the future difficulties. Stable family relationships and supportive parental guidance are extremely important modelling influence for children. A healthy family system would prevent adolescent’s abuse even in the face of heavy peer pressure. Many studies were conducted to investigate whether quality of life affected drug abuse behaviour (Guisinger & Blatt, 1994; Brook et al., 1990; Grotevant & Cooper, 1986; Gilligan, 1982) but all reporting equivocal results regarding significance of different family variables relating to different substance abuse. What is obvious in this context is that family is major contributory factor in substance abuse behaviors which implies that it must influence the detoxification treatment outcome also. As one of the major concerns of all efforts to understand causations of drug abuse behaviour is to devise successful treatment strategies so in any effort to bring about change in drug
abusers' behavior, the family factor needs to be focused on.

Individuals life events which cover social change and adversities especially if they are stressful can lead to various negative outcomes, like some psycho physiological disease or drug abuse. According to Selye (1974, 1976) stress is anything which causes an alteration of psychological homeostatic processes. According to Lazarus (1971) the term stress is applied to the fatal transaction between stress and the coping responses in interaction together overtime so that one may speak of a system being under stress as well as particular situation being stressful. A number of investigators have been particularly concerned with stressful life events or life stress. They pointed out that one that is discontented with his life and is unable to tolerate tension and stress is vulnerable to become drug abuser. The impact of stressful life events received attention of researchers but in most studies it has been dealt with in isolation with drug abuse (Windle et al., 1996; Burt et al., 1988; Baere et al., 1987). Desai et al. (1992) investigated feeling of stressful life events with regard to treatment of alcohol dependence. Few researchers have focused on stress as buffering effects of supportive social environments but evidence for this has been inconsistent (Windle, 1992, 1996; Dubois et al., 1992). Despite the widely shared assumption that people use drugs or alcohol to decrease stress, measures of stress do not consistently predict the substance abuse (Pihl & Smith, 1983). This might be due to the fact that objective stressors have substantially different meaning to different people thereby altering their effect across samples (Thoits, 1982). And secondly by individual's attitudes, values and resources such as social support which may significantly buffer or exacerbate the effect of a given stress on any aspect of behaviour (Hobfoll, 1985). Thus while investigating the drug abuse behaviour as related to stress that is a vulnerability factor, the psychopathology as well as ego strength of individual simultaneously needed to be accounted for.

In sum the present investigation tend to focus on these factors which seems to be the primary cause of drug abuse and addiction in people belonging to any socio economic strata as well as any age group. It is conjectured that if these factors tend to play primary role in initiating the drug abuse then these factors must be playing important role in affecting the treatment outcome also i.e. whether an
abuser/addict after substance detoxification would lead drug free life or would again relapse and resort to drugs. Hence the present study tends to focus on these individuals/drug abusers in terms of their ego factor i.e. level of ego integration. It is conjectured that normal as well as deviant aspect of an individual's personality functions can be better understood in terms of his ego-strength, a psychoanalytic construct playing central role in ego integration instead of a peace meal approach toward personality. Another factor of prime importance seems to be the psychosocial stressors. Though different people's reactions to various psychosocial stressors would largely depend upon their attitudes, perceptions and available psychological resources but still it is one of the most dominant factor in determining one's escapist behaviour in term of taking refuge in drugs. Psychopathology also seems to have major contribution in drug relapse.

NEED OF THE STUDY

Alarming rise in consumption of drugs especially opium and its derivatives by youth of rural as well as urban areas of Punjab and Haryana has ruined the carrier and structure of many families. In some areas identifiable narcotic subculture have come into existence where addiction is becoming a way of life. Though substance abuse problems have been found to be relatively more prominent in economically depressed families but some others in the face of minor threats, frustrations, disputes, disorders or under peer pressures also become easily a part of narcotic subcultures. With time, most addicts who join the drug cultures become increasingly withdrawn, indifferent to their families and society and abandon competitive and achievement strivings. Some of them develop full fledged psychiatric disorders. Many unhesitantly indulge in crime. Many addicts due to their unmindful indulgence in risky sexual behaviour are becoming high risk group for spread of AIDS also which nowadays has become priority area of health related agencies, in Punjab and Haryana. As a result of awareness campaign initiated by Governmental and other social organizations, addicts and their families have started approaching de-addiction centres for medical and psychological help to get rid of the problem. They are provided thorough medical and psychological treatment under the expert
supervision of hospital staff. Every addict remains under treatment approximately for three months. It has been found that some addicts respond to treatment successfully in the sense that they become able to get rid of the desire to reuse the drug. But a large number of cases after taking full course of treatment and reporting improvement in this regard relapse again and resort to the use of drugs. It seems extremely important to find out in what sense these relapse cases are different from those who recover completely after treatment. For that matter their intrapsychic factors and nature of psychosocial stress experienced by them need to be investigated so that appropriate strategies should be devised and measures taken to help them as well as their families and they could become respectable and effective members of the society.

OBJECTIVES OF THE STUDY

The present study starts with the following objectives:

1. To examine the level of ego strength in drug addicts who successfully respond to detoxification treatment and those who relapse after detoxification and resort to drugs again.

2. To examine the level of emotional stability in drug addicts who successfully respond to detoxification treatment and those who relapse afterwards.

3. To study the level of paranoid tendencies in drug addicts who successfully respond to detoxification treatment and those who relapse and resort to drugs again.

4. To study the level of guilt in drug addicts who complete the detoxification treatment successfully and those who relapse after detoxification and resort to drugs again.

5. To examine the level of frustrative tension in drug addicts who successfully respond to detoxification treatment and those who relapse and resort to drugs again.

6. To study the level of anxiety in drug addicts who successfully respond to detoxification treatment and those who relapse and resort to drugs again.
7. To examine the tendencies of depression in drug addicts of both the groups.
8. To understand the level of hopelessness in drug addicts who successfully respond to detoxification treatment and those who relapse afterwards.
9. To examine the nature of negative automatic thoughts in those drug addicts who remain abstinent after treatment and those who relapse afterwards.
10. To study the level of suicide ideation in drug addicts who successfully respond to detoxification treatment and those who relapse afterwards.
11. To examine the level of psychopathic deviation in drug addicts who remain abstinent and those who relapse after detoxification treatment and resort back to drugs.
12. To examine the level of schizophrenic tendencies in drug addicts who successfully respond to detoxification treatment and those who relapse and resort to drugs again.
13. To understand the level of manic tendencies in drug addicts who successfully respond to detoxification treatment and those who relapse after detoxification and resort to drugs again.
14. To examine the level of hysterical tendencies in drug addicts who successfully respond to detoxification treatment and those who relapse afterwards.
15. To understand the tendencies of repression-sensitization in those drug addicts who remain abstinent after treatment and those who relapse afterwards.
16. To assess the life satisfaction of drug abusers of both the groups.