CHAPTER-1
INTRODUCTION
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Drug abuse is one of the perennial and pervasive problems that countries all over the world have faced. It has become a universal concern of society to be specific and of the world in general during few decades. Seeding through the personal and family problems, it leads to behavioural problems and social difficulties of an individual. The problem of drug abuse has become a menace in our society and elsewhere in spite of a general awareness resulting physical and psychological damages.

In the fast changing scenario of the world, youths especially students of the youthful age are considered to be the future assets of the family and the nation at large. These youngsters can contribute a lot for the welfare and the advancement of the family or nation in a true global sense only if their energies and potentialities are channelized in the most appropriate and desired manners. On the contrary, if they indulge in undesirable activities, like drug addiction, which has become the most prevalent social evil in the present time, they can never utilize their potential and energies for self-growth, family welfare as well as for the welfare and development of the nation. The prevalence of an alarming growth rate of drug addiction warrants us to take preventive steps for the proper utilization of human resources.

In the light of above fact the problem merits attention of those concerned with the health. Health is considered as a state of complete physical mental and social well being "Mental Health" on the other hand is the capacity of an individual to form harmonious adjustment to social and physical environment. It is rooted in one's ability to balance feelings, desires, ambitions, ideas, situations and competence (Reddy &
Nagarathanamma, 1993). Elaridge (1970) points out that drug effect is only partially implemented to its direct action on body chemistry. The rest is attributable to psychological factors. Biological impact occurs when one is chronically dependent on drugs. The dependency however, starts through psychological obligation. Personality correlates are considered to be crucial integral part in determining the individual differences in response to various drugs. It is not confined to any particular socio-economic class or cultural group. It is a vital concern of the society in general. Incidence of drug abuse never the less has been found more among lower class, poorly educated and occupationall y unskilled groups. (Gupta et al., 1987; Bansal & Bannerjee 1993).

The decade of sixties have been a marked increase in the use of the psychoactive or mood altering drugs all over the world. The widespread use of such drugs crossed the permissible limits are termed as misuse. The misuses of drug have converted to ever increasing dependence or abuse (Coleman, 1972; Banks & Walles, 1988).

A drug is a chemical substance that changes the normal body functioning. When a pharmaceutical preparation or naturally growing substance is used, primarily to alter the physical or mental functioning of an individual to experience or relief from stresses or enjoy its elation is termed as drug. More precisely it refers to any chemical substance which affects bodily function, mood, perception or consciousness, which has potential for misuse and which may be harmful to the individual and society.

The pharmacological interpretation of a drug is any substance, other than food, whose chemical and physical nature alters structure or functions in a living organism (Ray, 1987). Painful agonising stresses,
loneliness or inquisitive attempt provokes the initial use and the individual is trapped.

**Drug Use**

Drugs may or may not have medical uses and their usage may or may not be legal when they are used to cure an illness, prevent a disease or improve the health conditions, it is termed "Drug use" and is socially acceptable feature of our society.

**Drug Misuse**

Drug misuse is consuming a drug for the purpose of fulfilling a need other than what the drug is capable of doing in the form of medicine. Misuse of drug indicates that it is being used in way that is likely to have deteriorating effects. This is characterized by social unacceptability, illegal practice and of physical harmfulness. Sometimes it emphasizes the intake in excess amount without medical approval and the action leads to habits formation.

**Drug Abuse**

Drug abuse is defined as it seriously interferes with health or occupational and social functioning. A never-ending need for "Euphoria" (a state of feeling really good) at times motivates abuse. When drugs are taken for reasons other than medical in any amount, strength, frequency or manner that damages the physical or mental functioning of an individual, it comes under drug abuse. Drug abuse has been considered as persistent or sporadic excessive use of drug in consistent with or unrelated to a complete medical practice. Resnich (1979) opined that drug abuse is continuous use of a psychoactive drug despite the occurrence of major problems associated with its use, for example
health, vocational, scholastic, legal, social or economic difficulties. The dosage levels significantly increase the hazard potential, whether or not the substance is used therapeutically, legally or as prescribed by a physician. Jaffe (1980) indicated that it is self-administration of any drug in a manner disapproved by medical or social norms of a given culture. Fred (1982) opined that drug abuse refers to the non-medical use of drugs and other substance for one or more of the following purposes to change the user's mood, to alter his perception of himself and the world around him, to produce novel sensations and experiences and to enhance his ability to function in certain settings, such as social or sexual one.

Drug abuse is often associated with addiction or dependence. WHO (1974), described the condition as a state, psychic and sometimes also physical resulting from the interaction between a living organism and a drug, characterized by behavioral and other response that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects and sometimes to avoid the discomfort of its absence.

Drug Habituation

Habituation is known as psychological dependence. It may be the first step towards physical dependence. WHO drew a distinction between 'addiction' and 'habituation'. Addiction meant compulsive use, a tendency to increase dosage, psychological and physical dependence and detrimental effects to the individuals and society. Habituation meant a desire for the drug, no tendency to increase dosage no physical dependence and only personal impairment.
Drug Addiction

Addiction as defined by WHO is "a behavioural pattern of drug use characterized by overwhelming involvement with the use of a drug, compulsive drug seeking behaviour and a high tendency to relapse after withdrawal". Besides it is viewed as a continuous relative to the degree when drug use affects the total quality of life to the drug user and to the range of circumstances in which it controls his behaviour.

Addiction may be explained with three important concepts; tolerance, physical dependence and psychological dependence. As the user's body adapts to the drug it develops tolerance. Such person needs increasingly higher drug doses in order to become intoxicated when the user's body becomes totally dependent.

On the drug with its prolonged use, the condition is defined as physical dependence. The body becomes so used to functioning under the influence of the drug that it functions normally only if the drug is present. Psychological dependence is a state characterized by emotional and mental preoccupation with the effects of the drug and by a persistent craving for it, the user gets mentally "hooked on" to the drug. If the intake is abruptly stopped the body becomes "Confused" and "protests" discomforts through convulsion depending on the type of drug abused. Reckless (1971) highlighted the definition of drug addiction with its euphoric or analgesic effect. Ahuja (1982) is of opinion that body becomes so dependent to the toxic effects of the drug that one just cannot do without it.
**Tolerance in drug usages**

Tolerance to a drug develops in an individual when the some dosage produces decreased effects after repeated use. The degree of tolerance and the rate at which it is acquired depends on the specific drug the person uses it and the frequency and magnitude of its use. Dosages of drugs that produce tolerance e.g. barbiturates & having tend to be increased by persons using them as their tolerance to a particular drug increases.

The mechanism by which physiological tolerance is acquired are not fully understood, there is some evidence that the central nervous system develops some degree of tolerance for various drugs, but addiction learning may play an important role in changing an individual's attitude towards a drug and its response to it after repeated use. Thus with some drugs such as marijuana, the individual may learn to control some effects and maintain relatively normal functioning.

Two aspects of drug tolerance that merit brief mention are "cross-tolerance and reverse tolerance". "Cross-tolerance" may occur when the individual who develops tolerance to one drug also shows tolerance to drug whose effects were similar. Ex-heavy drinker may not only show tolerance of alcohol but also to barbiturate, tranquilizers and anesthetics. "Reverse tolerance" may occur in the use of some drugs. Such as the psychodelics, herewith experience the desired effects may be achieved through the use of smaller doses. Psychological and physiological factors appear to play a significant part in this process.

*(Based on Commission of Inquiry into non-medical use of drugs, J.C. Coleman, 1970).*
Steps in the process of Drug abuse or Drug rejection

First Drug Experience

Primary psychological dependence (reward)

Minority of susceptible individuals
Intermittent or Chronic abuse of potent psychoactive drugs.

Stimulants
Cocaine, Amphetamine, Methamphetamine, Phenmetrazine

Hallucinogens
L.S.D. Marijuana, Mescaline, Others

Depressants
Alcohol, Barbiturates and others
Sedative-hypnotics, morphine and morphine like analgesics

Psycho toxicity

Acute effects Abuse on toxic doses

Chronic Effects

Tolerance Development

Physical dependence

Secondary psychological dependence (avoidance)

Continuous administration to avoid punishment

Drug withdrawal
Antisocial and /or criminal behaviour to obtain drug.
Severs, in the above model summarized the process of drug abuse and drug rejection and explored that it is based on the reinforcement factor. The behaviour may turn to be antisocial in case it starts with reward of primary psychological dependence, while rejection takes place with initial aversive experience.

Many drugs are such powerful immediate reinforcers that once allowed the psychoactive effect on society would be disastrous. A complete elimination of the impact is passively the only means to control drug dependence.

The diagram highlights the individual harm caused by psycho toxicity, which are the consequence of stimulants and hallucinogens with their acute effects and subsequently may develop antisocial or criminal behaviours. Positive reinforcement with the drug used introduces primary and secondary psychological dependence, which are due to uncontrollable compulsive abuse of any psychoactive drug.

The uses of depressants may develop secondary psychological dependence. Depressants introduce two separate phenomena; tolerance and physical dependence. Tolerance develops as vital organs of the body such as the nervous systems, the cardiovascular system and the respiratory system are directly affected and the activities are lessened. Continuous exposure of depressant drugs induce, increases nervous activity that is perceived only when drugs are discontinued and withdrawal or abstinence syndrome is observed. These two-phenomenon lead to psycho-toxicity from secondary psychological dependence. The avoidance of the particular depressant induce negative experience and if withdrawn the addict may turn to antisocial behaviour in order to fetch the required drug to continue its intake.
Drug addiction and mental abnormalities

A great amount of attention has been given to the relation of mental abnormalities and drug addiction. Generally speaking it has been found that drug addicts tend to be psychopathic, neurotic or otherwise in adequate personalities.

Four categories of today's disorder are considered basic to addiction:

1. Medical addicts used the drugs long after the medical treatment even after discontinuation of the treatment due to their emotional problems.

2. Psychoneurotic individuals who become addicted to the use of drugs in an effort to escape their problems as it relieve their anxieties.

3. This group is the largest and is made up of the so-called psychopaths. They seek the emotionally as well as pleasurable relief effects.

4. This small group consist of psychotic persons seeking to escape the difficulties of an every day life and become addicted, usually through a person already dependent upon drugs.

CLASSIFICATION OF ADDICTIVE DRUGS

Major categories of addictive drugs, either on the basis of chemical structure or mechanism of action is as follows: -

1. Narcotic analgesic.
2. Stimulants.
3. Depressants.
4. Hallucinogens.
5. Cannabis.
**ADDICTIVE DRUGS**

### Narcotic Analgesics
- Natural: Codeine, Morphine
- Semi Synthetic: Semi Synthetic, Methadone
- Synthetic: Synthetic

**EFFECTS**
- Euphoria, apathy, analgesia, mental clouding, drowsiness, low blood pressure, nausea, vomiting, dysphoria loss of appetite, constipation moodiness.

### Stimulants
- Natural: Stimulant
- Semi Synthetic: Semi Synthetic
- Synthetic: Synthetic

**EFFECTS**
- Euphoria, loss of appetite, delusion toxic psychosis, depression, convulsion, jitteriness.

### Depressants
- Natural: Depressant
- Semi Synthetic: Semi Synthetic
- Synthetic: Synthetic

**EFFECTS**
- Euphoria, sedation, poor motor co-ordination, impaired concentration and judgment short-term relief from anxiety and tension, nausea, abdominal pain, excitation.

### Hallucinogens
- Natural: Hallucinogens
- Semi Synthetic: Semi Synthetic
- Synthetic: Synthetic

**EFFECTS**
- Insightful experiences, exhilaration, distortion of sense, alteration of mood synesthesia, pseudo hallucinations, mild euphoria

### Cannabis
- Natural: Cannabis
- Semi Synthetic: Cannabis
- Synthetic: Cannabis

**EFFECTS**
- Mild euphoria increased perception possible psychological addiction, lung, memory and sexual damage.
Narcotic Analgesics

Narcotic analgesics are hard drugs that characteristically relieve pain and produce a state of tranquility, elatedness and sometimes sleep. This category consists largely of the opiates, the best known as opium, morphine, heroin, codeine and methadone. It has generally a depressant action on the entire central nervous system, including the centers controlling the most vital physiological functions.

Narcotics of natural origin is obtained from opium poppy. Morphine and codeine are extracted from opium. Raw opium contains about 10% by weight of morphine and smaller amount of codeine.

Morphine is semi synthetic group of Narcotics. Heroin is a semi synthetic a derivative of the drug morphine. Brown sugar is the adulterated form of heroin. Heroin crosses the blood-brain barrier faster than morphine, the onset of its effect in faster and the euphoria more intense (Merchant and Dorkings 1994). Pure heroine is a white crystalline powder with a bitter taste and quite costly drugs on per Indian standard. To increase the marketability of the drug an adulterated variety came into the market. Cleansing powder quinine, starch, maltose, agarbatti ash, chuna, dhatura and soap nut powder are added to heroine to increase the bulk of the drug (Banker & Waller, 1998). The colour varies from light to dark brown and is referred to as brown sugar and smack - Brown sugar concentrates in the tissues especially in the kidney, liver, skeletal muscle, lungs and spleen, yet small amount influence the pharmacological effect (Ranganathan, 1989).

Another narcotic analgesic, i.e. Buprenorphine was introduced as a patent analgesic with low abuse potential. It is a semi synthetic highly lipophilic opioid derived from the bains, an optimum alkaloid. It is a
cheap alternative to heroin (Singh et al., 1992). Reports of buprenorphine provided a slower onset and longer duration of both its effects and side effects compared to morphine. Further, the degree of respiratory and CNS depression as well as the withdrawal featured are relatively less with buprenorphine.

In India, buprenorphine was launched as an analgesic in 1986. Marketed as injectable preparation of 1ml and 2 ml (IM/IV) containing 0.3 mg and 0.6 mg of buprenorphine respectively, as well as 0.2 mg sublingual tablets, under the brand names of Morphine, Tidigesic, Temgesic etc. Just within one year of its release, heroin addicts were using it initially as self-medication for combating opioid withdrawal and later purely as a drug of abuse (Basu et al., 1994).

Synthetic narcotics are produced only in the laboratory. Methadone and meperidine are most widely available synthetic narcotic drugs. Meperidine (Pethidine), the pain reliever can be administered orally or injected. Methadone also relieves pain and as narcotic analgesic class of drugs, is highly addictive and regular use results in sevour physical and psychological dependence.

**Stimulants**

Stimulants are drugs, which excite or speed up the central nervous system. Cocaine and Amphetamines have chemical effects that stimulate or speed up the activity of the CNS. The most commonly abused stimulants are Benzedrine, Dexedrine and Methadrine.

The caffeine a minor stimulant stimulators. The capacity for muscular work and tended to result in decrease of discrimination reactiontive. Larger doses of caffeine found responsible for increased speed of reaction appear inconsistent.
Amphetamines are synthetic drugs usually taken orally. Their medical use is common to treat narcolepsy (an uncontrollable tendency to sleep) and hyper kinetic behaviour in children.

Cocaine, potent stimulants of natural origin, anaesthetize tissues and simultaneously constrict blood vessels and limited bleeding thus utilized in surgery. It is no longer employed medically.

**Depressants**

Depressants are drugs, which depress or slow down the functions of the nervous system. This group of drugs comprising sedative and hypnotics generally decreases central nervous system arousal although there may be psychological stimulation even at low doses. The drugs, which come under this category, include sedative hypnotic and alcohol. Sedative hypnotics are non-narcotic depressant drugs with calming effects, sedation or inducing sleep. Barbiturates and Benzodiazepines are two main drugs that fall into this category. Barbiturates act by depressing the activity of the entire CNS with some impairment of memory and cognitive processes. Barbiturates are medically prescribed for sedation and it reduces anxiety as well as convulsions (anti-seizure serum, e.g. Phenobarbital).

Benzodiazepines are also clinically used to reduce anxiety, induce sleep and muscle relaxation. These are used as preanesthetic medication and to control seizures. Some commonly prescribed benzodiazepines are diazepam, chlordiazepoxide, flurazepan etc.

Alcohol acts directly on the brain and changes its working ability. If alcohol taken in small quantities, it depresses that part of brain, which control inhibitions, and so the person feels relaxed when blood alcohol concentration is high, if it depresses the other area of CNS this result
inverse problems. Primarily its is a depressant, but in small doses it can act as a stimulant as well as a tranquillizer. It may cure mild depression but inevitably increases with continuing consumption.

**Hallucinogens**

Hallucinogens are drugs, which dramatically affects perception, emotion and mental process of abusers. Hallucinogens are also referred to as 'psychedelic' (mind altering) drugs. It is a wholly synthetic product to naturally occurring substances. Most common hallucinogenic drugs are: LSD (Lysergic acid diethyl amide), PCP (Plencylidie) and psilocybin, Mescaline etc. LSD a semi synthetic drug is produced from lysergic acid. It was used only as a research tool to study the mechanism of mental illness without any medical use. PCP is commonly called langeldust. It was synthesized and tested as a human anesthetic. Mescaline is derived from Mexican peyote cactus and spanpardo cactus and can also be produced synthetically. Psilocybin is chiefly derived from the 'Psilocycbe' mushroom. Except PSP all hallucinogens, such as LSD, mescaline, and psilocybin are used orally for their proper absorption. PCP is snorted smoked and eaten and are rarely taken intravenously.

**Cannabis**

Cannabis drugs are made from the Indian hemp plant - cannabis sativa, Marijuana comes from the leaves and flowering tops of the weed known as hemp or cannabis. Marijuana is related to the stronger drug, hashish, which is derived from the resin extracted by the cannabis plant and made into a gummy powder. As in the case with marijuana, hashish may be smoked, chewed or drunk. Three basic preparation of cannabis are in common use. The dried leaves and flowering tops of uncultivated plants are known as 'bhang' if it is infused and drunk and 'marijuana' if
it is smoked. The small upper leaves and flowering tops of cultivated plants are known as 'ganja' and is smoked. Cannabis resin is known as 'hashish' and usually is smoked. Chronic marijuana users have been described as having more anxious, paranoid, dependent, non-confirming hysterical and negativistic towards society than moderate user (Zimberg & Weil, 1970).

**Major Commonalities in Drug Dependency**

A number of major commonalities were observed in the following model of drug dependency by Marchant & Dorkings (1994).

Loss of self-control the pre-eminent criterion highlights that despite the best of intentions person engages in addictive behaviour...
involvement, the other common features found may include shared social rituals and self-acceptances of a label such as 'addict'. Substances regarded as addictive, generally produce marked alteration in mood, psychomotor skills, social behaviour and cognitive processes.

Repetition of a pattern or involvement in use is sometimes reinforced and habits are formed. Tolerance, indicates a progressive decrease in some of the effects such as, euphoria, analgesia etc. When discontinued it leads to with drawl effects which are extremely, unpleasant although rarely life threatening. The coping strategy viewpoint is that an addictive behaviour may relieve some intolerable emotional state for solving personal problems and escape pain. The rest of the commonalities in the model indicate social factors and biological as well genetic factors of drug dependency.

IMPACT OF DRUG ON ORGANISM

Research reports during the post three decades have highlighted three principal dimensions to study the impact of drug on organism namely biological psychological and sociological components (Sahilit & Gomberg 1991). The biological explorations indicated the following facts.

(1) Biological Aspects

The process of addiction involves alterations in brain functions. Neuroactive substances alter brain transmitter function. The drugs of primary concern are the opioids, stimulants (amphetamines, cocaine) and alcohol. Biological scientists attempted to reduce the extent of drug dependence. It was proved that drug addiction alters the brain function that results in positive change in mood. This can be euphoric elevation in mood or reduction of dysphonic mood. Drugs that release dopamine
or block dopamine reuptake presumably work by increasing dopamine concentration, which produces euphoria (Rothman et al., 1991). It is now possible to measure the dopamine uptake site in human beings with neuroimaging techniques (PET).

The brain makes a complex mixture of peptides that acts the endogenous transmitters at opioid receptors i.e. the B-endorphins and encephalin (London et al., 1990). Misused opioids such as, heroin act at the same receptors as the natural opioid system. The activity of noradrenergic neurons is decreased by opioids (Nutt 1996). Some clinical data suggests that longer-term reduction in nor adrenaline activity may predispose alcoholics to relapse and that drugs that selectively reverse this process may have clinical use (Borg et al., 1981).

Serotonin (S-HT) has many roles in brain function, but in relation to addiction the main ones relate to appetite, impulsivity and craving. Increasing brain S-HT functions by blocking its reuptake with selective serotonin reuptake inhibitors (SSRIs) reduces voluntary alcohol consumption is heavy social drinkers (Sellers et al., 1992).

The major excitatory and inhibitor transmitters in the brain are the closely related amino acids GABA (inhibitory) and glutamate (excitatory). The GABA receptor complex contains a binding site for the benzodiazepines, which is their sole site of action. Recent studies have revealed that intoxicating doses of benzodiazepine agonists occupy only about 30% of brain receptors (Malizia et al., 1995). There are at least 80 other brain neurotransmitters some of which are likely to be involved in addiction i.e., cholecystobinin.
(2) Psychological Aspects

The concept of psychological proneness towards addiction refers to characteristics within the addicts, which promote the use of drugs. Many studies, have demonstrated that some common personality traits are also prevalent among the drug abusers. They tend to score low on well being and self satisfaction, are inclined to be more non-firming more alone and isolated at home, less optimistic about vocational future and more disorganized under stress (Gautam et al., 1991; Craig 1979).

It is necessary to stress light on some of the observations, experienced by the present investigators, which is drug addicts develop psychological abnormality against their own social group. Excessive abuse creates difficult problems for the drug addicts, their families, and the production units to which the drug addicts are associated. It is true that drug change the user's mood or perception to self and environment. Drugs resolve their personal conflicts and serve as the principle mode of recreation and relaxation. Drugs provide relief from tension and physical exhaustion from prolonged work. There is growing evidence (Brock et al., 1980; Huba & Benter 1982) for the notion that certain personality characteristics such as less sense of personal responsibility (e.g. lack of achievement motivation) and less sense of social responsibility (e.g. delinquency) enhance adolescents proneness to drug abuse. An important study was conducted by Hill, Haetzen and Glaser (1960), they concluded that narcotic addicts are often psychopathic, that hospitalized adolescent and adult addicts do not differ in their Minnesota Multiphasic Personality Inventory (MMPI) profiles, that aa great similarities exist between adolescent addicts and delinquent non-addicts and that psychopathology is an important etiological element in addiction.
However very similar MMPI profiles have also been found not only in juvenile delinquents but also in hospitalized chronic alcoholics (Hill, Hoertzen and Davis 1962). Speculating on the commoners of elevated scores for psychopaths in the MMPI among narcotic and alcoholic subjects. Hill (1962) has suggested that the "social deviant" does not engage in the daily activities that are ordinarily reinforced by and satisfy the larger society. Counter anxieties and inhibitions that deter unusual behaviour in the mature adult do not do so in the social deviant. Thus, he is particularly vulnerable to short term satisfaction and can readily manipulate his personal affairs if drugs are available. The deviant who is immediate and inadequate is unable to solve problems of adult life independently may find temporary freedom from frustration and problem in alcohol or complete elimination of such problem in aviators. Moreover, other investigation has stressed "Passive dependency" as a dominant trait among opioid addicts. Wikler and Rosor (1953) have suggested that such individuals choose opioids for repeated use from among a number of other drugs, including alcohol, with which they have had experience presently because to them opioids facilitate their preferred mode of dealing with frustrating and anxiety - arousing situations - namely by promoting "indifference", as would in the use of alcohol. However, a major difficulty in relating personality characteristics as found in opioid addicts to the addiction process is the paucity of suitable control data.

Hill et al., (1962) while using the MMPI also compared 200 addicts with group of 199 hospitalized alcoholics and groups of 200 prisoners. Using, A factor and analytic technique, they identified three primary addict personality type (i) the undifferentiated psychopath (ii) the primary psychopath (iii) the neurotic psychopath.
In addition to the psychological aspects of drug addiction, it is necessary to mention that a high depression and psychopathic deviate (pd) score on the MMPI correlation with alcoholism and psychedelic flashbacks. Heatan & Victor (1976), Martin et al., (1977) have prepared that detoxified opium addicts and long abstaining chronic alcoholic have significantly elevated scores on the psychopathic deviate (pd). Hypomania and depression scales of the MMPI literature demonstrated that addicts consistently have significantly elevated scores on the psychopathic deviate (p.d. scale).

Veeraraghavan (1980) reported that main reasons for starting on drug habit as "experimentation " or curiosity (61.6%) followed by "Kicks". (36.1%) and "to get over problems regarding family, personal failure etc". (33.4%). Other reasons such as "to feel confident" " to remove boredom", "peer group pressures", "to intensity perception" and "aesthetic awareness" etc, were also advanced, but by a very few range (3.14%) drug abusers.

In one of the most important studies, Dhillan and Pawah (1981) found that drug users felt emotionally very insecure and compared to their normal colleagues as the had strong feelings of rejection, isolation of being unloved, anxiety, hostility, inferiority helplessness and inadequacy.

Thus studies revolve around the importance of psychological factors in drug addiction. It is to be pointed out that various scientists and others have obtained the "emotional" effects of morphine in a series of studies on "anxiety associated with the anticipation of pain" in post addicts. It is necessary to point out that the effects of single doses of morphine on the so called pain threshold are unpredictable (Andreus
1993; Denton and Beacher 1949). These investigator hypothesized that one important action of morphine in the production of analgesia is dissociation of "anxiety" from perception of the noxious stimulus. In agreement with this hypothesis others found that morphine (15mg) had no significant effect on the ability of post addicts to estimate intensities of brief but painful electric shocks under non-anxious conditions. Under "anxious" conditions untreated subjects over estimated the intensity of such stimuli, where as after injection of morphine they estimated an actual intensities of these stimuli and did not differ significantly. Likewise it has been reported that single doses of morphine (15 mg) significantly reduced the description of performance on a visual-manual reaction time test, produced by repeated self-inflicted electric shock penalties for slow reaction times an action not shared by pent bar betel (250 mg). Further evidence of the effectiveness of morphine in reaching "anxiety associated with anticipation of pain " was obtained by Kornetsky (1954) in a study on post addicts, employing radiant that stimuli instead of electric shocks. In addition to measurement of "Strong or weaker than standard" judgment of the noxious stimulus several measure of "anticipation" were included under both "anxious " and "non-anxious" conditions. It was found that morphine decreased significantly the number of stronger responses, as well as anticipatory psycho galvanic responses, only under "anxious" conditions. It is obviously clear from the mentioned study that at least in post addict's single doses of morphine reduces responses to a variety of stimuli that have in common the property of producing "emotional" arousal.

(3) Social Aspects

The taking of drugs is a culturally patterned behaviour. Both the prevalence and the consequences of drug use in society depends, much
upon social norms as well as on physiological responses to drugs or general psychological characteristics of drug users. In old days the use of drugs varied such as relief from pain, fatigue or anxiety, the celebration of social solidarity "kicks" and enhanced mystical experience. Beliefs about the effects of the substances used and the specific ends sought through such use are closely linked with more general cultural goals and orientation.

There is no evidence that addiction to drugs is favorably regarded in any society or culture but the status accorded to the addict varies markedly. It is important to mention here that in the United States, it has been defined as a criminal, stereotyped and a "dopefied". In most of Europe, on the other hand, the addict is viewed as an unfortunate person whose problem is primarily psychological and medical. It is a matter of fact that great differences exist in cultural orientation to specific drugs or drugs effects. We are however, far from being able to explain them. Opium and Hashish have been widely used in some specific society.

To cite another example a student of culture and personality has suggested that opium smoking was prevalent in China because it afforded a means of achieving the cultural goal of individual harmony with environment, but opium smoking did not exist in China until European traders introduced it in the seventeenth century (Sonnedeker, 1963). It is important to note that the East India Company, despite its protests by the Chinese government, subsequently forced opium upon the Chinese. An adequate understanding of drug use with in a given cultural requires knowledge of historical facts that is rarely available.
It is very important to note that there is no single causal pattern that fits all narcotic addiction. In addiction to the physiological and psychological dependence that itself becomes a driving factor, life stress, personal maladjustment and socio cultural conditions enter into the total causal picture.

Addiction indeed, is also associated with socio cultural aspects. The influence of socio-cultural factor in drug dependence including alcohol and opium addiction is well depicted in the experience of the Meo, a tribal people who inhabit the mountains of several countries in Southeast Asia (Westermeyer, 1971). In our society there are no opium dens, but there are so-called narcotic subculture in which it is easier for an addicts to participate in the drug culture. It is important to mention here that the decision to join this culture has important implications for the future life of an addict and people who have been there will center their activities around the role of a drug user, in short, their addiction becomes their way of life.

If we trace the historical background of social aspects of drug addiction, we find that through the Middle Ages, the primary use of opium was medical. The letters and records of European travelers in the orient during the middle ages occasionally refer to opium as a drug used by the people to overcome fatigue but they do not mention chronic intoxication or indicate recognition of the phenomena of tolerance and dependency (Sonnedecker 1963).

The extent of drug use and drug addiction, historically or currently, is known only in very general terms. The use of opiates and of marijuana and the so-called "dangerous drugs" is developed by the great
mass of the population, not only in western society but entire parts of
the nations of the world.

In general the prevailing sentiment toward drug use, even on the
parts of residents of slum areas, is decidedly negative. It is generally
seen that most children learn that most adults consider heroine and
marijuana "bad". In areas of highest drug use, however rejection of the
standards of conventional society distrust of policemen and relatively
favorable attitudes towards drugs tend to be much more widely
prevalent, even among a cross section of school children, than in other
areas of the city. (Chein et al., 1964).

As far as the attitudes towards drug-taking behaviour is concerned
it is to highlight that the literature is relatively silent regarding the
attitudes of the care givers and burden-shares of the drug dependent
person at home. In this regard, Rao and Kuruvilla (1992) studied and
found that the families of substance and of abuses have to bear a major
brunt on the problems posed by these persons and often find it difficult
to cope. Recently Basu, Malhotra, Verma and Malhotra (1977) have
pointed out that their own attitudes towards drug taking behaviour
would have an important bearing upon how they perceive and handle
the difficulties at helm. It could only be guessed here that the Western
researchers have neglected the study of this particular area because
there the management is more institutional and less family based
cultures.

Another major aspect of personality difference between the addict
and the non-addict is the low self-esteem and high degree of social
immobilization of narcotics user by virtue of anxiety. A major appeal to
the opiates is that they should permit the constricted ego greater escape and freedom (Chein 1964).

Having discussed the psychosocial aspect of drug addiction, it has been observed that there is a need to pay much more attention for finding out the constraints of drug abuse and it should strictly be resolved by giving intervention strategies in an appropriate style. It is a fact that drug addiction is a social evil not only in India alone but entire parts of the world. Although, in various countries, governments are also engaged in stopping drug abuse but parents, friends, teachers, learning centers, institution etc. may also play a vital role. Imparting educational programs related to drug abuse. These programs may help at an impressionable age by the child.

CONCEPTS IN THE PRESENT RESEARCH

PERSONALITY

Depression

The term "Depression" is used for a complex of symptoms: a "depressed" despondent condition, unresponsiveness and loss of drive, motor and mental inhibition, typically depressive ideas and definite somatic disorders. One most significant variety is endogenous depression, which is constitutionally grounded, dependent on heredity and tender to manic-depressive illness. The characteristics symptoms of endogenous depression area ground less deeply felt sadness (Melancholia), anxiety or excitement and typical sometimes imaginary, ideas of impoverishment; self accusation, a conviction of sinfulness, as well as depersonalization, with a tormenting loss of emotional life. In addition there is an inadequacy, which is experienced mentally and physically as hypochondria, as well as somatic disorders in the form of
insomnia, periodical fluctuations of emotional condition with a morning "low" loss of appetite and weight and vegetative disorders.

**Forms of Depression**

According to the symptoms, there are *inhibited depression* in which the inhibition can be intensified and become stupor; agitated, i.e. anxiously *exitd depression*, *hypochondriac depression*, which are felt entirely somatically and occur within the area of physical feelings and related anxieties. *Paranoiac depression* is characterized by imaginary feelings of guilt and ideas of injury. *In vegetative depressions* as in other forms, actual melancholia may be quite absent. In *manic-depressive* psychoses, approximately half of all cases experience the various phases in the form of depression; in a quarter of cases there are both depressive and manic phases, and in another quarter there are only manic phases. There is an essential danger of suicide in *endogenous depression*. It is rare for the thought of suicide not to occur and in 10-15% of the cases the patient actually attempts to take his own life. The condition runs in phases, with an average duration of six months. The single phase dose not lead to any change in personality, in contrast to the schizophrenic shift.

Unlike the *endogenous depression*, in a *reactive depression*, the depressive resentment remains more or less explicable on normal psychological grounds, as a quantitative increase of normal sadness; it thus appears as an adequate reaction to stressful events of an acute or chronic nature whose contribution to the causation of the depression can be recognized by the patient too. Exhaustion depressions are also largely to be understood in a normal psychological sense, as cases of depressive reactions to chronic somatic and mental over-strain. Neurotic
depression are said to arise from unresolved conflicts in the unconscious; they are more or less repressed and mostly of a chronic nature and frequently derive from childhood. They often feature aggressive, hysterical and demonstrative characteristics, which are not found as a rule in endogenous depression. A causative factor in symptomatic depression is temporary exogenous or endogenous somatic damage linked to some cerebral injury. In contrast to endogenous and symptomatic depressive moods, which can be limited in time, in depressive psychopaths there is a very deeply rooted and lasting depressive mood without enjoyment of life or confidence and a tendency to treat everything with pessimism.

Anxiety

The term anxiety was introduced into psychology when Freud (1894) described the anxiety neurosis as a syndrome distinct from neurasthenia. But its acceptance in the discipline did not become general until more than forty years later. May (1950) has noted that, outside the publications of psychoanalytic writers, anxiety was not even listed in the indexes of psychological books written before the late 1930s.

In his earliest formulations Freud considered anxiety to be the outcome of repressed somatic sexual tensions. He believed that libidinal images that were perceived or dangerous were repressed; and that the libidinal energy was cut off from normal expression and transformed into anxiety. He later replaced this notion with the much broader conception of anxiety as a signal for danger; distinguishing now between objective anxiety and neurotic anxiety, depending on whether the danger came from the outside world or from internal impulses.
May (1950) characterized anxiety as "the apprehension caused by a threat to some value the individual holds essential to his existence as a personality".

Sullivan (1953) referred to it as the state of tension arising from the experience of disapproval in interpersonal relations.

According to Wolpe (1952), "Anxiety is the autonomic response pattern characteristic of a particular individual organism after the administration of a noxious stimulus. The pattern varies from one individual to the next.

The autonomic events that make up an anxiety response are predominantly functions of the sympathetic division of the autonomic nervous system. Common manifestation of the sympathetic responses is; increased heart rate, sweating of the palms and dilatation of the pupils and dryness of mouth. Some parasympathetic responses may also occur as diarrhea, nausea, vomiting, and frequency of urination. This is possibly related to the general rise in muscle tension that is ordinarily so constant an accompaniment of anxiety (Jacobson, 1938).

Conditions of Anxiety

Many everyday situations arouse anxieties in the individual who suffers from undefined fears. These situations may be merely uncomfortable for a normal person but for the highly anxious they are unbearable. At last library card, a stopped up sink, or a sarcastic remark can be a condition of crisis in the life of an anxiety driven person. The following categories are particularly disturbing to him.

1. If put in a situation from which escape is impossible, he becomes severely disturbed. He will try to avoid such situation. If unsuccessful in doing so, he may develop physical symptoms
of illness as manifestation of his anxiety. Furthermore, this type of anxiety leads to all sorts of social deception.

2. The anxious individual is terrified of any situation in which he can perceive even the slightest possibility of personal failure. People sometimes develop personality disorders as a result of earlier childhood punishment. After repeated and severe punishment, the threat of punishment can become so great that it produces fear out of proportion to the punishment. Transferring such threat related anxieties in to adult life, the individual may respond anxiously to situation in which there is any chance of failure.

3. The individual becomes anxious when separated from his source of support. The most obvious examples is the child who is lost while outing with his parents. The anxious person sometimes seems inflexible in his behaviour. This is because he depends on so many external things for support and cannot be separated from these props without further anxiety and upset.

**Stress**

The term - "Stress" has been widely and indiscriminately used; its most precise definition is that of Selye (1950). He restricts the concept of stress to a characteristic physiological response, differentiating this from "Stressors"- the agents that produce stress.

This bodily reaction is manifested through the symptoms of a general adaptation syndrome. When the stress is prolonged, the syndrome typically includes three stages.

(a) An alarm reaction, including an initial phase of lowered resistance and a counter stocks phase, in which defensive mechanism begin to
operate (b) a stage of resistance in which adaptation is optimal, and (c) a stage of exhaustion, marked by the collapse of the adaptive response.

The features of this reaction are organized around the pituitary-adrenal cortical axis. Selye (1950) describes the triad of the alarm reaction as enlargement of the adrenals, shrinkage of the thymus and lymph nodes and gastrointestinal ulceration.

The nature of pituitary adrenal involvement has been much debated, and the physiological mechanisms involved in the stress reaction have been extensively investigated (Goldstein & Ramey, 1957; Oben, 1967).

Attempts to extend Selye's idea of systemic stress to include psychological aspect have met with many problems. Firstly the nature of stressors is very different: Selye discussed such systemic stressor agents as hot cold, infections intoxicants, injury shock and surgical trauma.

The range of psychological stressors is so wide as to be virtually endless. Cofer & Appley argue that there are affective only when they threaten the life or integrity of the individual exposed to them. They offer a definition of stress as "The state of an organism when he perceives that his well-being is endangered and that he must elevate all of his energies to its protection". (Cofer & Appley, 1964).

Secondly the nature of physiological reaction is not now seen as a general well-defined pattern. Central issues in psychological stress are the conditions and processes (a) that load the individual to differentiate between begin and damaging conditions, and (b) that determine the kind of coping behaviour which ensues. Recent analyses emphasize the role of cognitive appraisal (Lazarus, 1966). Once a stimulus has been
appraised as threatening, various methods of coping are adapted. Pribram (1967) has suggested that cognitive re-evaluation may obviate the necessity for overt behavioural adjustment; that is, an individual's appraisal of the situation can reduce the stress reaction.

When examined in a psychological context, the stress reaction must therefore take account of complex cognitive processes as well as physiological reaction and feedback from the effects of these reactions. For example it is often undifferentiated from anxiety, conflict, emotion, frustration and arousal.

Stress is a personal response to a certain variation in the environment stress can be differently perceived depending on (a) The nature and magnitude of the strategy; (b) the importance of the stressor to the individual; (c) the perception of the threat element as a component of the stressor; (d) the personal and social support system available to the individual; (e) The involvement and willingness on the part of the individual 'to do something' about the state of stress, Pestonjee has viewed sources of stress in light of social systems to which we all belong. There is two such a systems. One is the primary system such as family and religions, regional and linguistic groups and the other is the secondary system to which we relate such as neighbourhood, schools, colleges, technical institute and work organization. As the functional requirement and role expectation from both these system differ, the demands made on the individual in one system have their effect on his performance in the other, have their effect on his performance in the other, moreover, resources from one system and also be invested in the other system to take care of the problems arising in it.
He has defined three important sectors of life in which stress originates. These are (a) jobs and the organization, (b) Social sector, and (c) inter psychic sector. The first namely, job and organization refers to the totality of the work involvement (task, atmosphere, colleagues, compensations, policies, etc.). The social sector refers to the social cultural context of one's life. It may include religion, caste, language, dress and other such factor. The interapsychic sector encompasses those things, which are intimate and personal, like temperament, values, abilities and health. It is contended that stress can originate in any of these three sectors or in combination thereof.

Response to stress can be grouped into three categories (1) Physiological responses (2) Behavioural responses, including expressions of affect; and (3) Subjective state, self-report (Moss 1973). According to Selye (1956) physiological response to the stress involves these stages (1) Alarm reaction (2) The stage of resistance involving an increased capacity for the organism to responded; and (3) Exhaustion characterized by a loss of functional capacity to continue. Physiological response is an increase in central and autonomic nervous system activity as well as endocrinal physiological response inadequate blood pressure, respiration, vasomotor constrictions, galvanic skin response as well as changes in endocrines activity. The magnitude of this physiological reaction has prompted observation to link it with disease. Thus Engal (1962); Lowenthal and Chirbaga (1973) have suggested that disease may be a response to stress or in same instances it may be the stressor.

Behavioural response used as operational definitions of stress have included erratic performance rate male-coordination, increase in errors. Fatigue, preservative behavior and so on. Including among such
behaviours as reflective of emotional state (and therefore of stress) are tremors, stuttering, exaggerated speech characteristic etc. The presence of emotional activity has been used post facto to indicate subjective state and usually refer to any bodily changes deviating from usual or normal states such as anxiety, fear, tension, reported somatic symptom, depression, and the like. In addition, interview and test responses have been utilized for such descriptive work (Pichot 1971).

Stress response are divided into several patterns; those involving active copying "(Fight or Flight)", Those associated with an aversion situation or long-term monitoring (vigilance), and those characterized by subordination, in which active copying is attempted but is not successful. In the fight or flight reaction, the release of catecholamines raise the blood pressure and heart rate, with increased cardiac output and decreased total peripheral resistance. The vigilance response, which seem to mediated by the pituitary-adrenocortical system, result in elevated blood pressure with increased total peripheral resistance but deceased heart rate and Cardiac output.

Richard Lazarus elaborated the concept of individualized response to stress. Proposing that responses are determined by the manner in which person appraises and copes with stressful event. Hence, a person's reaction to stress depends on the appraisal of the event and the person's belief in his or her ability to manage or cope with the stress, the person's attitude regarding the significance of the outcome of the stressful event is also considered important. The reality of the stress is of less important than the person's cognitive assessment or it determining the subsequent emotional and physiological reactions.
Harold Wolff's fundamental premises were that disease is a failure or inability to adopt life stress. Wolff's theory heralded the concept that they way in, which a person is able to cope with stressful event, is a critical, factor in determining the magnitude of subsequent physiological effects. Events are deemed to be stressful only if the person perceives that the stress threatens life, well-being or emotional security.

Wolff and Wolff also observed that the physiological state of the gastrointestinal tract appear to correlate with specific emotional state (hyper function with hostility and hypertension with sadness). Never the less, they regarded such reaction as relatively nonspecific, believing that the patient's reaction is determined by general life situation and perceptual appraisal of the stressful event. Wolff also emphasized that the capacity to adapt to a threatening events determines that nature and severity of psycho physiological response patterns. Familial discord, emotional deprivation, goal frustration, object loss, separation and unemployment were emphasized.

The term stress is used to connote a variety of meaning both by the common man and psychologist of different persuasion have given (a) stimulus-oriented (b) response-oriented (both physiological and behavioural) definition of the term and depth. (c) Psychologists have treated the concept from the etiological and psychodynamic viewpoints. It appears that under these circumstances the essential feature of the stress experience have not received the attention they deserve (Astruna, 1983).

Aggression

Controversy begins in the study of human aggression. Conflicting stances have been taken as to the fundamental nature of man, the role
of learning and experience in the development of aggressive tendencies, how aggression is best controlled, the relation between the instigation to aggression and other types of motivation and even what standards of evidence are required for theoretical propositions.

The roots of aggression

Although the nonspecialist is opt to view much of the controversy as a dispute between those whose biological orientation stresses the role of innate determinants, and those who emphasize the role of learning and experience, the major arguments really center upon endogenous versus exogenous causation. Writers such as Freud (1948); Storr (1968) and Lorenz (1963) trace the main springs of aggression primarily to internal sources and assume that man has a spontaneously engendered drive impelling him to attack and even destroy other persons; they maintain that this energy must be discharged, if uncontrolled explosions of violence and perhaps even suicide are not to occur. However some critics of this reasoning have also expressed a strong biological emphasis while still disputing the idea of an internally generated aggressive drive.

Also highly questionable is the Freudian, Lorenzien conception of a unitary aggressive drive that supposedly powers a wide variety of non-aggressive as well as aggressive actions. In agreement with many other students of animal behaviour, Scott insists that there is no single instigation to aggression. Fighting serves a number of different functions and has a multiplicity of causes. Moyer (1968) has presented a list of different kinds of aggression (predatory, inter male, fear-induced, irritable, territorial defense, maternal and instrumental) and suggest that each type has a somewhat different basis in physiological
mechanism and eliciting stimuli. At the human level, Berkowitz (1962) maintains that instrumental aggression, which is governed by anticipated rewards, must be differentiated from impulsive aggression, which is evoked, by situational cues in a manner akin to conditioned responses. The unitary aggressive drive conception is highly dubious and by leading investigators to neglect or deny the operation of many different casual factors, may even be an impediment to more adequate formulation, as R.A. Hinde (1959) has argued in his discussion of unitary drive theories.

Nor in the apparent generality of aggressive behavior adequate support for the unitary - aggressive - drive theory. A hostile person may display certain other traits, but the correlation between hostility and these other characteristics is no proof that one trait has caused the others. Furthermore the unitary drive idea of energy flowing from one type of behaviour to another must be differentiated from the more precisely defined response generalization concept developed by experimental psychologists. Research has shown that reinforcement provided for a certain reaction can strengthen other, similar responses. Rewarding one class of aggressive responses, such as hostile remarks, can increase the likelihood of other kinds of aggressive behaviour. The reinforcement influence generalizes from one act to the others because they have something in common; perhaps the aggressor regards all of these as hurting someone. Whatever the exact meaning of the various aggressive actions, it is theoretically unparsimonious to interpret response generalization as energy transfer from one response channel to another.

Berkowitz (1969) has suggested that the frustration aggression relation may be a special case of the connection between aversive stimuli.
and aggression. Thwarting are noxious events in important respects and pain is a reliable stimulus to fighting. In this regards, Scott believes social fighting has evolved from defensive reaction to pain. We should note, however, that the aversive stimulus also produces a heightened arousal state, which can increase responsibility to the dominant aggressive cues in the environment.

**Inferiority feelings**

Individuals generally feel inferiority because they perceive that they are lacking in one of the following areas: physical condition or limitations, intelligence level, education level, emotional well-being, social environment or financial condition.

The striving for superiority is to overcome or improve one or more of the above areas. Also the feeling of inferiority is one of the areas can be so strong that the individual feels hopeless and fails to even attempt to improve their life. One can also be improve one or more of the other areas. For example, a person can strive to obtain a higher educational level in order to improve their social and economic level.

**Adler** did not consider feeling of inferiority as a sign of weakness but as a "Well spring of creativity" and the source of human determination and striving. Again, the definition of inferiority does not mean what you might think. It is not an inferiority complex or an overall feeling of inferiority to other. It means that you feel that you can improve an aspect of your life if you become better at a task, knowledge or skill. Accomplishments in life are driven by an effort to overcome inferiority feelings and it is our energy source. We strive to make our lives better and have a superior live in the future.
The term "feeling of inferiority" is a construct used by Adler to describe one pole of his teleological view of the personality - the other pole represented by the fictional final goal. Adler's assumption was that the child has a sense of smallness, weakness, helplessness, dependency and powerlessness could experience inferiority. Once a final goal has been adopted, the imagined distance to that goal can also induce sense of inferiority. Adler claimed that an individual would do almost anything to cover up, relieve or escape the experience of inferiority. This experience is probably a blending of thinking, feeling, imagination and sensing.

The inferiority feeling represents a generic "felt minus" that Adler assumed was present, in varying degrees, in everyone. Adler initially envisioned all psychological movement as starting from a "felt minus" situation or position and leading to an "imagined plus" situation or position. These movements may be cognitive, affective or behavioural and are generally a mixture of all three. Psychological problems develop when a very deep feeling of inferiority spark highly exaggerated, fictional goals of striving for superiority over other people. While initially Adler emphasized the "pushing" motivation of a feeling of inferiority, later on he emphasized the "pulling" motivation of a striving for completion. (This is similar to Abraham Maslow's concepts of deficiency and growth motivation).

A client may have single or multiple inferiority feelings; they may be moderate, strong or divesting. Inferiority feelings may be rooted in physical, intellectual, social or economic felt deficiencies. The symptom can be felt or expressed as insecurity, frustration or anxiety.
The specific type of inferiority is usually unconscious in the client and hidden from the observer. Identifying the specific inferiority feeling does not come mainly from direct observation. A series of earliest recollections often provide the most fertile clues. If the clinician guesses correctly, and approaches the client gently and respectfully, there is generally a very clear emotional "recognition reflex". In therapy we gradually uncover, precisely describe and then gradually dissolve each individual's unique, core inferiority feeling. We also identify reveal, and try to diminish the height and modify the direction of the compensatory fictional goal. Unless we change both ends of this system, symptoms, and dysfunctional compensatory strivings may persist.

SOCIAL ASPECTS

Normative Behaviour

It deals with behavioural tendencies, which are largely concerned with compliance to norms shared by a cultural group. It is an important component of social approval. Norms although they are rarely spelt in explicit manner, work as anchors of behaviour. These norms define the course of action prescribed, hence distinguish approved behaviour from non-approved one's. Coffmen (1971) reported that self-presentation is governed strongly by social norms. Norms govern what people can do. Norms also suggest that people should accept the self-presentation of other people and not challenge the veracity of what another person says. In every day social interactions norms have powerful consequences. They tend to guarantee that people will come to receive acceptance for their self-presentation unless, of course, these presentations are widely out of line. Norms are more than standards; they declare what is normative or appropriate. Most people not only prefer polite behaviour but also indeed
come to expect it. Normative behaviours are useful in gaining approval. Norms ensure regularity in human behaviour so that people need not worry about a wide range of things. Norms provide useful social service, norms serve as substitutes for indirect social influence (Horton et al., 1963; Jabins 1960).

Social Conformity

Social conformity facilitates social interaction. Members of the society are able to assume that others will behave in certain ways; this makes life much simpler. Conformity allows society to operate smoothly; people can interpret correctly what others are doing and can communicate easily. Thus behaving in the same way as those around us do is highly adaptive. Similarity among the members of a culture in due to similar backgrounds, experience and learning. All children learn to do the same things in the same or similar ways; when they grow up, as adults they behave in similar ways, because that is the way they learned to behave.

Allan (1965) has defined conformity operationally as "a change in the behaviour of a person due to group influence resulting in the increased congruence between the individual and the group". Krech et al., (1962) assert that the essence of conformity is the yielding to group pressures. They also proceed to asserts that conformity implies a conflict, there is conflict between the forces in the individual which tend to lead him to value, believe and act in one way, while the pressures emanating from the society or group tend to lead him to believe and act in another way. When an individual has to express his opinion regarding some issue, when his conviction is at variance with the expressed judgment of the other members of the group, he is placed in a conflict
situation. He may express his own deviant judgment and remain independent of the group consensus or he may conform by announcing his agreement with the group judgment. Thus conformity arises in response to group pressure. The response may be merely verbal or it may take the form of overt action and when some students on strike pelt stones at the policemen or at the bus, the others also join them in pelting stones.

The conformity may be true conformity when the individual agrees with the group both inwardly and outwardly, that is, when conviction and action agree, or it may be an expedient conformity where the individual may agree outwardly but remains in disagreement inwardly. Kelman (1958) called such expedient conformity or compliance. Thus conformity as well as compliance indicate that the individual has yielded to group pressure; in conformity there is a agreement with the group, both inwardly and outwardly, in conviction as well as in action; in compliance there is only agreement in action or expression but not in conviction.

**Positive Self-Presentation**

It refers to the content of self-disclosure to other people. While both verbal and non-verbal behaviour communicate information about individual, more concentration is on verbal form, since verbal information is easier to measure. There are two dimensions of self-presentation process the positiveness or negativeness of a person's self-disclosure and the intimacy level of information. There is reason to believe that these dimensions serve different functions in self-presentation behaviour. Self-disclosure or intimacy behaviour usually functions as a trust building mechanism. The Positiveness of self-
presentation, on the other hand, is useful primarily for gaining approval and other types of rewards from other people. Disclosing private information about oneself encourages others to do so also and probably acts to promote trust among people, where as saying positive things often gains approval from others. There is no necessary suggestion that because person tells intimate details of his or her life, that person wants to build trust or that if the person provides positive self description he or she is trying to win social approval. Under a wide variety of circumstances, self-disclosure infacts leads to trust and positive self-presentation to approval. Seeking approval, people may try to make their presentations appear to be consistent with other aspects of themselves. It is evident that how positively people describe themselves is affected by their desire for and ability to get approval (Schneider & Turbat, 1975).

Positive self-descriptions contribute to development of relationship. Although self-presentation helps not only in development of relationship, but can also be used to exploit relationship. Positive self-presentation has been described as an important element in the building of personal relationships. People who behave in a pro-social manner and who have positive characteristics are typically better liked than those who do not. Most people are well aware of the fact that certain forms of behaviour are more likely to gain approval than other forms of behaviour. The fact that these ways of gaining approval are widely known means, among other things can be exploited by any person who classes to use them in an unscrupulous way. Under the circumstances then people may be motivated to cheat on normative system, that is, they may be inclined to try to get approval through self-misrepresentation.
Defensiveness

It is a tendency of avoidance or control against a threat from inner or outer world of individual. One of the significant ingredients of human personality is ego and threat to ego is not a comfortable state. Consequently one tries to defend it in such situations. We adopt a variety of strategies to get rid of threats to ego. Sometimes anticipated threats do influence present behaviour. People try to 'manage' threatening situations in effective manner. They for instance, seek justifications as well as rationalizations for this purpose. The person who needs approval does not want to be 'cornered'. He makes best of his efforts to present good account of himself in the eyes of others (Barthel & Crowne 1962; McGinnes 1949; Marlouse & Crowne 1964).

Dependency

The state of an individual when economically, emotionally or otherwise dependent on other individuals. Also used to refer to the relation of the immature child to those who care for or guide it.

In socialization, dependence of the child on a person to whom it can relate (Mother or parents, and so on), is the necessary premises for the social imitation of different behaviour patterns and for the internalization of social norms and values.

A condition for the development of the child's dependence on or trust in is presence of parents or an appropriate person to whom it can refer and with whom it can identify. If such a person is not available, partly irreversible damage can result in all areas of child development.

A possible explanation for the origin of dependent behaviour in the child is the principle of secondary reinforcement (Mowrer, 1950). The
behaviour of the persons to whom it refers takes on reinforcing (reward) qualities for the child, through respected association, with the satisfaction of primary or bodily needs by these persons. Their reinforcement value is transferred to all aspects of those person's behaviours; the child learns to place a positive value on their presence and attention. Dependence is also intensified by an upbringing and education oriented to warmth and love.

Social Responsiveness

The dimension of responsiveness has physical as well as social dimensions along which individuals differ. A study of temporal quality in human reactions to stimuli has a long history and is an established reality. In contrast, social responsiveness has been neglected as a variable in its own status. The dichotomy of extroversion /introversion does imply such difference but it is loaded with surplus meaning. In the present context social stimuli is high frequency and magnitude. In social situations he tends to react and sometimes over react to social stimuli (Crowne and Strickland1901; Marlowe 1962).

Social Approval

It refers to active approval seeking from the agents of social reinforcement, because for approval it is an important incentive for motivated person. The behavioural tendencies implied inactive approval seeking, require the individual to associate with or approach to or engage in such activities or social interactions that lead to attainment of approval from individual groups, or any other social organization which is perceived directly or indirectly by the individual as socially desirable.
SELF ESTEEM

Every individual has concepts and beliefs about the self and in the evaluation process he attaches a value to information about some object or procedure. "Self-concept" refers the information one has about one's self. In "Self-concept", the 'Self becomes the object of one's knowing, which also include other environmental events. Several scholars tried to differentiate "Self concept" and "Self-Esteem". One significant conclusion can easily be drawn on the basis of their result that "Self-concept" is developed earlier than "Self-Esteem". Because "Self-concept" is seen as the way an individual perceives himself in terms of ability, value, worth, limitation, etc. It is the substantative description; one's employed to identify his nature. "Self-Esteem" arises out of the individual's ability to estimate his own strengths and weakness (Calhaun, Dr. and Morse 1977).

"Self concept" involves description whereas "Self esteem involves an additional evaluation component and satisfaction" Pride is one common synonym of "Self-Esteem", "self love another". (Allport 1961).

Rosenberg (1965) suggests on the basis of extensive research that "Self-Esteem" has positive or negative attitude towards a particularly object namely, the 'self'. Edler (1968) defined "Self Esteem" as "Feeling of personal worth influenced by performance, abilities, appearance and judgment of significant to others. It indicates that satisfaction is an important element of "Self Esteem". According to him, "Self-Esteem results when the child is able to produce success for important facts of experience."

All individuals have "Self -Esteem" but it may range from high to low because on establishment a concept of himself lead to the ability to
determine whether or not, he is satisfied with what he sees about himself and every individual sooner or later must establish a concept of himself. "High self-esteem" indicates worth, value and high regard. "Self concept' tends to remain a more stable constant phenomenon while "Self esteem tends to fluctuate readily from time to time. The "Self-concept" is developed before the age of five and then basically remains constant (Perkings 1975; Wylie 1961). While "Self Esteem" is developed later and vacillates according to success or failure of the individual in their encounters. Coopersmith (1959) stated that 'Self-Esteem' is an ephemeral subject difficult to deal with empirically. Similar indications given by Gegan (1971) that, "Self esteem" is neither global nor fixed. It is not essential that if a person has positive "Self-concept" he has also a positive "Self-esteem", he may have negative,"Self-Esteem" concurrently.

Self-theories

Several psychologists have proposed theories of "Self" (Freud, Cooby, Mead, Erikson and Sullivan). Meed and Cooley argued that the "Self" emerged in three sequential phases and in each phase the child was progressively better able to differentiate "Self" from other. These phase were termed as "play", the game and the generalized other: According to Lindesmith et al., (1977) - " The "Self" for Meed and Cooley, reflected constant, interaction between (1) the individuals definitions of situation and (2) the definition reflected to the individual by others. Cooley located the emergence of the "Self" in the primary group of the family need, on the other hand, argue that the genius of "Self" was based not on self-feeling pursue, but upon the child's ability to reflexively respond to the attitude of the other."
Freudian Concepts

In Freudian theory, the main emphasis was on sexual experiences. He believed that sexual experiences or sexual drive is the major motivating force for the human organism. Benedek (1962) summarized the general Freudian theories of personality development in the following manner:

The integration of the sexual drive from its pre-genital sources to the genital sources to the genital primary and to functional maturity is the axis around which the organisation of the personality takes place. From the point of view of personality development, the process of interaction is the same in both sex.

On the basis of his psycho-analytical theory of development, the early development and emergence of 'self' is described in terms of the dominance of certain sensitive or 'egocentric', zones such as the oral and genital regions. Benedek (1952) says that, "Toilet training is the ego's first conscious struggle for mastery over an id impulse." The ego in the absence of mother resists the id impulse at this stage and a clash between 'pleasure' and 'reality' principle emerges which lead to important link to his 'self'. In the third phase of phallic, child's, sexual urges now become directed to environmental objects-toward the parent of the opposite sex. Boys get earlier awareness of genital gratification from girls. The girl's awareness of genital gratification is slower and more complex and after lengthy conflicts and vacillation, she develops her own kind of Oedipus complex the Electra complex. At this oedipal period the 'superego' develops and is in conflict with id Now ego or 'self' in undertakes the function of mediating between (1) the 'id' and the 'superego' and (2) the 'id' and the 'reality'.
Erikson's Model

Erikson also proposed a model of developmental stage depend upon the Freudian's approach Erikson, after rethinking Freud's theory of infantile sexuality and developed a diagram that emphasizes the step-by-step nature of the mind's development.

Erikson's step-by-step nature of the mind's development can easily be linked to the sequences of social experiences. Here he emphasized on critical periods that the child must manage, either doing in the fine manner or failing in some degree (Coles 1972). Coles writes "It the chart... lists a series of conflicts or crises, we do not consider all development as series of crises. Development proceeds 'by critical steps-critical being a characteristic of turning points, of moments of decision between progress and regression, integration and retardation."

Erikson has given more importance to family psychic health and the sequence of social experience in the emergence and development of 'self'. But the clinical psychologists underscored his chart, which certainly has an important place in 'self' theory particularly at adolescence stage (Schwartz and Kahne, 1973).

Landesmith (1977) writes - "Erikson's scheme may be restricted to only certain classes of individuals. Finally with his emphasis on sequential identity crises in adolescence, Erikson often gives less attention to the transformation in 'self' which occur in middle and late adulthood. The foundations of these identity crises are also not fully clear. They, too, may be relevant only to certain groups of individuals."

Sullivan's Interpersonal Theory

Sullivan's theory is based on the location of the origins of the 'self' in interpersonal relationship. Actually he extended contents of Cooley
and Mead's work on 'self'. Although he developed his theory on the basis of his experience with psychiatric patients like Freud, but his developmental scheme overcomes many of the flaws of Freud and Erikson. He was convinced with the nature of communications because of great difficulty of communication with psychiatric patients. He has given more importance of communicative process and the cultural milieu in his theory. He believes that the avoidance of severe anxiety is central to human behaviour and self-system starts to develop in infancy as a protection against this severe anxiety. The process of 'selective inattention' is an important role. According to Sullivan there are three modes or types of experience.

1. Prototoxic: In which experiences consist mainly of discrete series of momentary state, which can neither be recalled nor discussed.

2. Parataxic: This mode of experience ties between Prototaxic and Synataxic. According to Sullivan (1953), "In it experiences is partially organized or organized in a quasi-logical manner, but there are also elements of which the individual is unaware."

3. Synataxic: It involves a maximum of inner organisation and elaboration, full of symbolic formulation and is logically ordered so it can be discussed.

At first child's experiences are in prototaxic mode but with the interaction of environment and learning of language he is capable of reaching the parataxic level and synataxic level respectively. He has given new term to sexual drive - 'The cust dynamism' which arises at puberty stage. Sullivan's considered that mostly human needs arise in
interpersonal interaction and get satisfaction through interaction in highly complex ways.

**Adolescent Self**

Sullivan’s theory seem to be much more attractive than either that of Freud or Erikson. He has described the development as well as the nature of ‘self’ at adolescence period. Sorenson (1962) has characterized it - "Adolescence is much more than one rung up the ladder from childhood. It is a built in, necessary, transition period of ego development. It is a leave taking of the dependencies of childhood and a precious reach for adulthood. An adolescent is a traveller who has left one place and has not reached the next... It is an intermission between earlier freedoms.... and subsequent responsibilities and commitments.... a last hesitation before... serious commitments of work and love."

Sullivan (1953) writes in following manners regarding the importance of self-esteem at this age.

"Thus satisfying one’s last must be a considerable example to one’s self-esteem, since the bad girls are unworthy and not really people in the sense that good girls are.... The trouble is that just is a part of personality, and no one can get very far at completing his personality development in this way."

**OBJECTIVES OF THE STUDY**

In the light of not only national but increasing international problem of Drug addiction among youngsters the researchers thought to workout on the serious problems at small level with limited number sample because of many constrains. The objectives of the present study are:
1. To study the personality aspect of drug addicts such as depression, anxiety, stress, aggression & hostility, insecurity, inferiority feelings, adjustment and suspiciousness.

2. To study the strength of motive of drug addicts to seek social approval of different social aspects, such as normative behaviour, social conformity, positive self-presentation, defensiveness, dependency, social responsiveness and social approval.

3. To study the level of self esteem among drug addicts.

4. To study and compare the responses of the drug addicts with the normal subjects.

5. To make aware to the parents, society and social workers the consequences of Drug abuses among youngesters.

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