CHAPTER I
INTRODUCTION

Drug addiction is a crucial problem of contemporary society as its drastic consequences are associated with physical health and well-being, absolute loss of mental faculties and antisocial behaviour etc. According to Rajamanickan (1992) more than 50 percent of drug addicts were found to be infected with Human Immunodeficiency Virus (HIV) as they often resort to intervention injection through uncleaned syringes and needles, and therefore drug addiction becomes one of the important cause of AIDS.

According to World Health Organization (2007), problem of drug addiction is not new to us, but it has taken threatening form since last few decades. In the present situation, drug addiction has increased far more quickly and has now become an international problem. An estimated 4.7% of the global population aged 15 to 64, or 185 million people, consume illicit drugs annually (WHO, 2007). Reports indicate that drug addiction is increasing at a rate higher than that of population growth. However, this statistics is based only on cases that are reported through clinics or those which come into direct conflict with the law.

Palola, Dorpal & Larson (1962) in their study observed that 23 percent attempted suicides and 31 percent completed suicides involved alcoholism.
Fowler, Rich & Young (1986) in their study of 283 suicides suggested substances use disorder could be a major contributing factor in the rising suicide rate.

Drug dependence has been popularly described as overpowering the impulses through narcotics or intoxication. Drugs have been regarded as a problem because they are said to impair an individual ability to mobilize him and direct his life not meaningful to him or to the society. Some drugs are believed to undermine moral restraints and lead to criminality and violence.

A major chunk of studies centre around exploring factors which lead to drug addiction, psychiatric, marital or legal problems in the family, lack of emotional support from parents are linked to increase use of cigarettes marjuwana and alcohol (Cadoret, Yates, Troughton, Woodworth & Stewart 1995a; Wills, Duttamel & Vaccaro, 1995). Longitudinal studies have shown that a lack of parental monitoring leads to increased association with drug abusing peers and subsequent higher use of drugs (Chassin, Curran, Hussong & Colder, 1996; Thomas, Reifman, Barnes & Farrell, 2000).

Ann, Krig, Davison & Johnson (2007) identified psychological factors in drug abuse (particularly alcohol and nicotine) on mood, tenure reduction affect and the role of cognition in this process. There are other psychological disorders and personality traits, that may make it more likely for some people to use drug heavily and addict to it. Researches also suggest a reciprocal relationship between expectancies and alcohol use, positive expectancies predict alcohol use, and alcohol use helps to strengthen positive expectancies
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(e.g. Sher. Wood, Wood & Raskin, 1996). Anxiety (e.g. worries about things, fear of new situations) and novelty seeking (e.g. being restless, fidgety) predicted the onset of getting drug using and smoking.

The drug problem has become more acute and alarming as reported by the studies relating to drug abuse. The rate of drug abuse amongst student - population has gone up phenomenally. The cases of these hard-core addicts and ex-addicts are reported to be largely in the age group of 20-30 of age. Main causes towards drug indulgence particularly among adolescents are family conflicts and poor communication at home, apathy and alienation rejection of parental and social values, social incentives like acceptability, availability and vast appealing publicity through media, culturally and socially permissive attitude for drugs, continued loneliness, deprivation of affection, personal failure in a competitive society, aggressive, impulsive, search for personal identity, search of feelings for adulthood and their expression, subconscious destructive motives, desire to experiment, inability to accept oneself, absence of positive values and lack of correct ideology in personal and found much less among neurotics and psychotics as compared to general population.

Thus the major thrust of the present study is to investigate the problem of drug-addiction in relation to perceived home environment, feeling of insecurity and approval motive. The concern of the present study centers around these factors because till now very few investigator has taken them for research. In the same manner, age has also been found to be related with drug behavior. Age reflects different phases of physical, psychological and social
consequences associated with various biochemical and hormonal process that are different at different stages of life. This implies that younger and older groups also reflect certain distinctiveness in drug behavior. Age therefore, is identified an important variable to understand the problem of drug-addiction.

1.1 DRUG ADDICTION

Drug abuse behaviour is based on pathological need for substance such as alcohol, cocaine, opium, morphine, heroin, marijuana, hashish, LSD etc. These drugs affect mental functioning, physical health, social relations, and also psychological wellbeing. Therefore, drug abuse has a wide range of definitions related to taking a psychoactive drug or performance enhancing drug for a non-therapeutic use. Some of the drugs often associated with this term include alcohol, amphetamines, barbiturates, benzodiazepines, cocaine, methaqualone and opium alkaloids etc. Public health practitioners have attempted to look at drug abuse from a broader perspective than the individual, emphasizing the role of society, culture and availability. Rather than accepting the loaded terms alcohol or drug "abuse." many public health professionals have adopted phrases such as "substance and alcohol type problems" or "harmful/problematic use" of drugs.

The Health Officers Council of British Columbia (2005), A Public Health Approach to Drug Control in Canada — has adopted a public health model of psychoactive substance use that challenges the simplistic black-and-white construction of the binary (or complementary) antonyms "use" vs.
"abuse". This model explicitly recognizes a spectrum of use, ranging from beneficial use to chronic dependence.

In the modern medical profession, the two most used diagnostic tools in the world, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders DSM-IV (1994) and the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (1999), no longer recognize 'drug abuse' as a current medical diagnosis. Instead, DSM-IV has adopted substance abuse as a blanket term to include drug abuse and other things. ICD refrains from using either "substance abuse" or "drug abuse", instead using the term "harmful use" to cover physical or psychological harm to the user from use. Physical dependence, abuse of, and withdrawal from drugs and other miscellaneous substances is outlined in the Diagnostic and Statistical Manual of Mental Disorders DSM-IV. It's section Substance dependence begin with "Substance dependence When an individual persists in use of alcohol or other drugs despite problems related to use of the substance, substance dependence may be diagnosed. Compulsive and repetitive use may result in tolerance to the effect of the drug and withdrawal symptoms when use is reduced or stopped. This, along with Substance Abuse are considered Substance Use Disorders." However, other definitions differ; they may entail psychological or physical dependence, and may focus on treatment and prevention in terms of the social consequences of substance uses. In the early 1900s, the first edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders referred to both alcohol
and drug abuse as part of Sociopathic Personality Disturbances, which were thought to be symptoms of deeper psychological disorders or moral weakness. By the third edition, in the 1940s, drug abuse was grouped into 'substance abuse'.

Glasscote, R.M., Sussex, J.N., Jaffe, J.H., Ball, J. & Brill, L. (1932) created a definition that used legality, social acceptability, and even cultural familiarity as qualifying factors: as a general rule, we reserve the term drug abuse to apply to the illegal, non-medical use of a limited number of substances, most of them drugs, which have properties of altering the mental state in ways that are considered by social norms and defined by statute to be inappropriate, undesirable, harmful, threatening, or, at minimum, culture-alien.

American Medical Association (AMA) (1966) defined abuse of stimulants (amphetamines, primarily) in terms of 'medical supervision', 'use' refers to the proper place of stimulants in medical practice; 'misuse' applies to the physician's role in initiating a potentially dangerous course of therapy; and 'abuse' refers to self-administration of these drugs without medical supervision and particularly in large doses that may lead to psychological dependency, tolerance and abnormal behavior. The declaration from United Nation's (UN) Commission of Narcotic Drugs (2009) with participation from 130 member countries, state that “We are determined to tackle the world drug problem and to actively promote a society free of drug abuse.” The concept drug abuse is used five times in the declaration.
Burke, O'Sullivan & Vaughan (2005) stated that depending on the actual compound, drug misuse including alcohol may lead to health problems, social problems, morbidity, injuries, unprotected sex, violence, deaths, motor vehicle accidents, homicides, suicides, mortality, physical dependence or psychological addiction. Evans & Sullivan (2001) stated that drug abuse, including alcohol and prescription drugs can induce symptomatology which resembles mental illness. This can occur both in the intoxicated state and also during the withdrawal state. In some cases these substance induced psychiatric disorders can persist long after detoxification, such as prolonged psychosis or depression after amphetamine or cocaine abuse. A protracted withdrawal syndrome can also occur with symptoms persisting for months after cessation of use. Benzodiazepines are the most notable drug for inducing prolonged withdrawal effects with symptoms sometimes persisting for years after cessation of use. Abuse of hallucinogens can trigger delusional and other psychotic phenomena long after cessation of use and cannabis may trigger panic attacks during intoxication and with use it may cause a state similar to dysthymia. Severe anxiety and depression are commonly induced by sustained alcohol abuse which in most cases abates with prolonged abstinence. Even moderate alcohol sustained use may increase anxiety and depression levels in some individuals. In most cases these drug induced psychiatric disorders fade away with prolonged abstinence.

Jaffe (1975) in his study stated that drug abuse makes central nervous system (CNS) effects, which produce changes in mood, levels of awareness or
perceptions and sensations. Most of these drugs also alter systems other than the CNS. Some of these are often thought of as being abused. Some drugs appear to be more likely to lead to uncontrolled use than others.

Board on Behavioral, Cognitive, and Sensory Sciences and Education (BCSSE). (2004) reports that Traditionally, new pharmacotherapies are quickly adopted in primary care settings, however, drugs for substance abuse treatment have faced many barriers. Naltrexone, a drug originally marketed under the name "ReVia," and now marketed in intramuscular formulation as "Vivitrol" or in oral formulation as a generic, is a medication approved for the treatment of alcohol dependence. This drug has reached very few patients. This may be due to a number of factors, including resistance by Addiction Medicine specialists and lack of resources. In 1966, the American Medical Association’s Committee on Alcoholism and Addiction defined abuse of stimulants (amphetamines, primarily) in terms of 'medical supervision', 'use' refers to the proper place of stimulants in medical practice; 'misuse' applies to the physician’s role in initiating a potentially dangerous course of therapy; and 'abuse' refers to self-administration of these drugs without medical supervision and particularly in large doses that may lead to psychological dependency, tolerance and abnormal behavior.

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individual persists in use of alcohol or other drugs despite problems related to use of the substance, may be diagnosed. Compulsive and repetitive use may result in tolerance to the effect of the drug and withdrawal symptoms when use is reduced or stopped. However, other definitions differ; they entail psychological or physical dependence, and may focus on treatment and prevention in terms of the social consequences of substance uses. APA DSM-IV (1994) criteria for substance dependence includes several specifies, one of which outlines whether substance dependence is with physiologic dependence (evidence of tolerance or withdrawal) or without physiologic dependence (no evidence of tolerance or withdrawal). In addition, remission categories are classified into four subtypes: (1) full, (2) early partial, (3) sustained, and (4) sustained partial; on the basis of whether any of the criteria for abuse or dependence have been met and over what time frame. Substance dependence is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following, occurring within a 12-month period APA DSM-IV (1994):

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (such as repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; or neglect of children or household).
1.2 DSM-IV SUBSTANCE DEPENDENCE CRITERIA

Addiction termed substance dependence by the APA (1994) is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   (a) A need for markedly increased amounts of the substance to achieve intoxication or the desired effect, or
   (b) Markedly diminished effect with continued use of the same amount of the substance.

2. Withdrawal, as manifested by either of the following:
   (a) The characteristic withdrawal syndrome for the substance, or
(b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

3. The substance is often taken in larger amounts or over a longer period than intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

6. Important social, occupational, or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance (for example, current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

WHO (1999) The Expert Committee on Drugs defines drug addiction as: “A state of periodic or chronic intoxication produced by the repeated consumption of a drug whether it is natural or synthetic. Its characteristics includes: an overpowering desire or compulsion to continue taking the drug and to obtain it by any means; a tendency to increase the dose; a psychological and sometimes physical dependence on the effects of the drug; and finally an effect detrimental to the individual and to society.” According
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to Isbell & White (1953), this definition includes opiates, synthetic analgesics, hypnotics, sedatives such as barbiturates, hydrate of chloral, paraldehyde and bromides, alcohol, cocaine, certain sympathicomimetic amines such as amphetamine and methamphetamine, mescaline and marihuana.

According to Coleman, Butcher & Carson (1964), drug abuse is associated with many behavioral problems including aggression, assault, abuse, maltreatment and neglect. Drug addicts commit different offenses that range from minor offenses to most serious forms of crimes such as rape, assaults, murders, manslaughter charges, child abuse and suicides. Generally people begin taking drugs for a variety of reasons. Most abused drugs produce intense feelings of pleasure. This initial sensation of euphoria is followed by other effects, which differ with the type of drug used. For example, with stimulants such as cocaine, the “high” is followed by feelings of power, self-confidence, and increased energy. In contrast, the euphoria caused by opiates such as heroin is followed by feelings of relaxation and satisfaction. While some people who suffer from social anxiety, stress-related disorders, and depression begin abusing drugs in an attempt to lessen feelings of distress. Stress can play a major role in beginning drug use, continuing drug abuse, or relapse in patients recovering from addiction. Initially people may perceive positive effects with drug use and may believe that they can control their use; however, drugs can quickly take over their lives. Over time, if drug use continues, pleasurable activities become less pleasurable, and drug abuse becomes necessary for
abusers to simply feel “normal.” It has been noted that substance abuse disorders do not have just one cause. There are many, and they often combine to produce physical, psychological, behavioural and psychological effects.

1.3 COMMONLY ABUSED DRUGS

According to The National Institute on Drug Abuse NIDA (2008), the following list of drugs and substances are the most commonly abused. List of drugs and substances commonly abused are:

**Cannabinoids:** Hashish, Marijuana

**Depressants:** Barbiturates, Benodiazepines, Flunitrazepam (Rohypnol), GHB, Methaqualone (Quaaludes)

**Dissociative Anesthetics:** Ketamine, PCP

**Hallucinogens:** LSD, Mescaline, Psilocybin

**Opioids and Morphine:** Codeine, Fentanyl, Heroin, Morphine, Opium

**Stimulants:** Amphetamine, Cocaine, Ecstasy, (MDMA), Methamphetamine, Methylphenidate (Ritalin), Nicotine

**Other Compounds:** Anabolic Steroids, Inhalants

As discussed earlier, some of these drugs, such as alcohol and nicotine etc., can be purchased legally by adults; others, such as barbiturates etc., can be used legally, but under medical supervision only; while still others, such as heroin etc., are illegal. Many of these drugs are either swallowed or smoked, while still others are injected. Taking drugs by injection can increase the risk.
of infection through needle contamination and may also result in diseases like HIV or Hepatitis.

Use and abuse of substances such as cigarettes, alcohol, and other illegal drugs may begin in childhood or the teen years. Certain risk factors may increase someone’s likelihood to abuse substances. Factors within a family that influence a child’s early development have been shown to be related to increased risk of drug abuse, these include: Chaotic home environment, Ineffective parenting and Lack of nurturing and parental attachment.

Apart from factors within the family other factors related to a child’s socialization outside the family may also increase risk of drug abuse, these include: Inappropriately aggressive or shy behavior in the classroom, Poor social coping skills, Poor school performance, Association with a deviant peer group, and Perception of approval of drug use behavior. Therefore, variables like perceived home environment, feeling of insecurity and approval motive were selected to be used for this research.

1.4 DRUG ABUSE IN INDIA

India with a population of over 1 billion people, has about 3 million estimated victims of different kinds of drug usages, excluding alcohol dependence. Such population comes from diverse socio-economic, cultural, religious and linguistic backgrounds. The use of dependence-producing substances, in some form or the other, has been a universal phenomenon. In 2004 United Nations Office on Drugs and Crime and Ministry of Social Justice and Empowerment, Government of India (2004).
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Over the years, drug addiction is becoming an area of concern as traditional moorings, effective social taboos, emphasis on self-restraint and pervasive control and discipline of the joint family and community are eroding. The processes of industrialization, urbanization and migration have led to loosening of the traditional methods of social control rendering an individual vulnerable to the stresses and strains of modern life. The fast changing social milieu, among other factors, is mainly contributing to the proliferation of drug abuse, both of traditional and of new psychoactive substances UNODC & MSJE (2004), found that the introduction of synthetic drugs and intravenous drug use leading to HIV/AIDS has added a new dimension to the problem, especially in the Northeast states of the country. The survey and studies indicate a high concentration of drug addiction in certain social segments and high-risk groups, such as, commercial sex workers, transportation workers, and street children and in the northeastern states/border areas and opium growing regions of the country. The situation in northeast states has been little aggravated due to high incidence of Intravenous Drug Use (IDU), especially in the state of Manipur, leading to HIV/AIDS. The sero-positivity amongst them is about 70%. UNODC & MSJE (2004).

1.5 HOME ENVIRONMENT

A home is a place of residence, where an individual or a family can rest in and be able to store personal property. While a house (or other residential dwelling) is often referred to as a “home”, the concept of “home” is a much broader idea which exceeds the denotation of a physical dwelling. Many
people think of home in terms of where they grew up and is also used for various residential institutions which aspire to create a home-like atmosphere, such as a retirement home, a nursing home, a group home (an orphanage for children, a retirement home for adults, a treatment facility, etc., or a foster home, etc.

The notion of home concerns the cultural, demographic and psychological meanings we attach to this physical structure. The environmental psychologist Altman (1975) distinguishes five dimensions of residence: 1. Permanent versus temporary, 2. Differentiated versus homogenous, 3. Communality versus non-communality, 4. Identity versus communality, 5. Openness versus closeness. These dimensions are assumed to vary across cultures; however, the psychological effects of these variations are largely unknown! One important issue in this respect would be what happens across these dimensions when a person moves from one type of home to another. Moreover, home can be characterized along six dimensions: It should be a Haven, providing security, refuge and protection. It should have Order, both spatially and temporally, it should express Identity, which would be a result of the transformation from house to home, it should provide Connectedness: to people, place, the past, and the future, it should radiate Warmth both symbolical and interpersonal, and finally it ought to be Physically suitable in order to match the psychological needs of its users. Since it can be said that humans are generally creatures of habit, the state of a person’s home has been known to psychologically influence their behavior, emotions, and overall
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mental health. Within the daily lives of older adults, the home environment looms large. Later life transitions such as retirement from work, generalized social disengagement (Cumming & Henry, 1961), and declines in health or physical function contribute to a convergence of everyday activities within the home. Long-term care arrangements are also increasingly taking place within the context of the home (Wahl & Gitlin, 2003), since many older adults prefer to remain in their homes as long as possible. Attachments to place grow stronger as people age, and most elderly individuals associate remaining in their homes with increased quality of life (Gitlin 2003; Zingmark, Norberg & Sandman 1995). All told, it is estimated that the average older adult spends about 80 percent of his or her time inside the home (Horgas et al., 1998; Wahl & Gitlin 2003).

Most sociological research involving the home environment focuses primarily on living arrangements and family relationships (Hughes & Waite 2002; Jersey, Brown, Krause, Ofstedal & Bennett 2005; Umberson 1987), and some past work has examined the effects of household crowding (e.g., Gove, Hughes & Galle 1979). An investigation into the causes and effects of physical features of the home environment is long overdue, and would contribute to current sociological research in two important ways. First, status-based differences in home environments may contribute to health disparities. Individuals of low socio-economic status are more likely to reside in dilapidated, messy, noisy, and otherwise stressful home environments (Evans & Kantrowitz 2002). If the home environment affects health, then disparities in
living conditions may provide another mechanism through which low status translates to worse health outcomes.

Second, the positive effects of social relationships on physical and mental health are well-established (Berkman & Glass 2000; House, Landis & Umberson 1988; Thoits 1995). Yet, the home environment may be closely related to both health and social relationships. Features of the home environment may negatively affect health, but one's ability to maintain her home environment is likely affected by her health. Similarly, social support may mean that an individual has help with maintaining her home, but an unpleasant home environment may create conflict among co-residents or discomfort for visitors, ultimately leading to the erosion of social relationships and support. These complex interrelations among health, social life, and the home environment suggest that the maintenance of a comfortable living space may be a key factor for healthy aging.

NIDA (2008) in their report stated that “The influence of the home environment is usually most important in childhood. Parents or older family members who abuse alcohol or drugs, or who engage in criminal behavior, can increase children's risks of developing their own drug problems. Friends and acquaintances have the greatest influence during adolescence. Drug-abusing peers can sway even those without risk factors to try drugs for the first time. Academic failure or poor social skills can put a child further at risk for drug abuse. Hughes & Waite (2002) stated that the household is a key, if not the central, social context of everyday life. It is within the household that
individuals typically engage in their primary social roles as spouse, parent, or child. Individuals living together are usually family members, and familial relationships tend to be multidimensional, emotionally close, and infused with norms and histories that render them the most important relationships in an individual's life. In addition to being a central site for interactions with co-residents, the home is also a common location for interactions with members of one's close social network (Bronfenbrenner & Evans 2000). These close social network ties, along with relationships within the home, constitute valuable sources of social support. Co-residence, for example, allows mutual monitoring of health (Umberson 1987), pooling of economic resources (Becker 1981), and sharing of burdens of housework (Bianchi et al., 2000). Furthermore, in times of need, household members can assist with coping activities, mitigate the effects of illnesses or chronic conditions, and allow flexibility in roles and obligations in the face of illness, functional limitations, or cognitive decline (Waite & Hughes 1999).

Fullilove & Fullilove (2000) state that the interior environment of the home is a resource that can promote residents' health, safety, positive social relationships, and cultural identity. However, the extent to which home environments serve as resources for health and social relationships likely varies widely. Previous research, however, has not fully examined the extent of the variation, and its causes and consequences for individuals' health and social relationships. Pleasant home environments protect health, while dilapidated, stressful, or uncomfortable home environments likely take a toll on one's
physical and mental health. Similarly, some home environments provide better contexts for the development and maintenance of social relationships compared to others. Welcoming, comfortable, pleasant interior spaces probably promote positive social relationships and interactions, while uncomfortable or disorderly homes may create conflict among residents and discourage visitation from non-resident friends and family members.

Evans & Kantrowitz (2002) observed that home environment serves as a resource for the maintenance of good health and positive social relationships. Poor living conditions can negatively affect both physical and mental health. In this way, a potential causal pathway exists in which the relationship between social status characteristics and health disparities is partially explained by variations in features of the home environment.

Social relationships and social support may be key factors in the determination of conditions of one’s home environment. Geographical proximity, frequency of interaction, and relationship closeness likely affects the extent to which a family member or friend will help with home maintenance (Haines et al., 1996; Thoits 1995). A congenial home environment gives a sense of social support and cooperation amongst the inmates. However, disorderly home environments may create conflict or strain among household members and discomfort for visitors. A disruptive home environment may impede communication between individuals (e.g., if distracting noises or odors are present), and home environments that are perceived as unsafe or uncomfortable may cause others to curtail their visits altogether.
Neil (1996), Morenoff, Sampson, Robert & Raudenbush (2001) and Sampson (1992) in their studies reported that neighborhood disorder is correlated with delinquent behavior, and it can hamper one's ability to draw upon social support networks. Similarly, disorderly home environment may diminish one's ability to develop and maintain social relationships. Disturbing conditions of the home environment may lead to behaviors that result in lower-quality relationships with co-residents and inhibit social connections with others. For example, aggressive behavior has been linked to chronic exposure to noise (Cohen & Spacapan 1984) and unpleasant odors (Rotton 1983). When individuals are in a context filled with distracting noise, they are less likely to help others and children in classrooms with low lighting or unpleasant odors are less cooperative (Bell, Baldwin & Schottenfeld 2001; Heschong, Wright & Okura 2002; Kuller & Lindsten 1992). The conceptualization of the home environment as a resource for the maintenance of health and social relationships is supported by results indicating that those who suffer health problems and those who have lower levels of social connectedness and support tend to reside in worse home environments. The consistency of the relationships is actually quite remarkable. Across aspects of physical health, mental health, physical function, cognitive function, and sensory function, those who have better health also enjoy more well-kept homes, more clean and tidy living spaces, and more pleasant ambient conditions inside the home. Similarly, those who have more social relationships and more reliable support also enjoy better home environments.
Researchers have been struggling to identify the risk factors that can lead to drug and alcohol dependency, particularly among adolescents. Some of these are now widely recognized. Environmental factors such as family substance abuse, domestic violence, child abuse, excessively harsh discipline, lack of affection, parental neglect, and living in an environment where drug and alcohol abuse is common are all risk factors. According to the NIDA (2008), adolescents with psychosocial problems such as depression or violent behaviors are also more likely to use cigarettes or engage in "binge" drinking and much more likely to use marijuana than those with little or no indication of such problems.

According to Schuckit (1998), adolescents who had high problem scores during the past six months were more likely to have used cigarettes or engaged in binge drinking (five or more drinks on the same occasion) in the past month and much more likely to have used marijuana during that time, compared to those with lower problem scores. "Puberty is a major risk point for many psychiatric disorders," Schuckit (1998). It is not surprising, he adds, that it also a high-risk time for drug use. Therefore, home environment is the first and perhaps the most enduring context for growth, not only physically but also psychologically. Healthy home environment leads to identifying with models, accepting values, playing out family roles, developing affection, and eventually distinguishing one's own values and goal. Human beings are always immersed in a social environment which not only changes the very structure of the
individual or just compels him to recognize facts but also provides him with a ready-made system of signs. It imposes on him a series of obligations.

According to Misra (1983) two, environments namely home and school environments, share an influential space in individual’s life. Family is the social-biological unit that exerts the greatest influence on the development and perpetuation of the individual’s behaviour. The psychosocial atmosphere of a home may fall into any of the four quadrants, each of which represents one of the four general combinations: acceptance - autonomy, acceptance - control, rejection - autonomy and rejection - control.

Grebow (1973) reported that ‘nurture-affection’ and ‘achievement, expectations, demands and standard’ constitute the two dimensions of parental behaviour that have been regarded as important by previous researchers. Various researchers have identified the following characteristics of home environment or parental child rearing practices - permissiveness, willingness to devote time to the child, parental guidance, parental aspiration for achievement, provisions for the child’s intellectual needs, affective reward, instrumental companionship, prescription, physical punishment, principled discipline, neglect, deprivation of privileges, protectiveness, power, achievement demands, indulgence, conformity, independence, dependence, emotional and verbal responsivity, involvement with the child, physical and temporal environment, avoidance of restriction and punishment, provision of appropriate play materials, etc. There exists a great overlapping in the kinds of behaviour which are in association with different characteristics.
Becker (1981) reported that the deprivation of needed resources, normally supplied by parents, range from food and shelter, to love and attention. Parental deprivation of such resources can occur in several forms. It can occur in intact families or broken families. But the most severe manifestation of deprivation is usually seen among abandoned or orphaned children. We can interpret the consequence of parental deprivation from several psychosocial viewpoints. Such deprivation may result in fixation at the oral stage of psycho sexual development (Freud), it might interfere with the development of basic trust (Erikson), it might stunt the development of the child’s capacity for relatively anxiety-free exchanges of tenderness and intimate with others (Sullivan), it might retard the attainment of needed skills because of a lack of available reinforcements (Skinner), or it might result in the child acquiring dysfunctional schemes and self-schemas in which relationships are represented as unstable, untrustworthy, and without affection. Most children subjected to parental deprivation are not separated from their parents but suffer from inadequate care at home. Parental rejection of a child may be demonstrated in various ways - by physical neglect, denial of love and affection, lack of interest in child’s activities and achievements, failure to spend time with the child, and lack of respect for the child’s rights and feelings. In a minority of cases, it also involves cruel and abusive treatment. Parental rejection may be partial or complete, passive or active, subtly or overtly cruel.

Biller (1974) and Hetherington (1966) stated that inadequate parenting styles, parental psychopathology, marital discord, divorce etc. also effect home
environment to a great extent. Even though vast majority of families have two parents present, the rate of single parent families is increasing. Many psychologists feel that absence of same sex parent leads to maladjustment, delinquency, academic under achievement, and emotional immaturity. Failure to identify with a parent of the same sex has been viewed as a cause for those problems. Many researchers feel that alcoholism or drug abuse tends to run in families. Genetic factors may be an influence, it is clear that an alcoholic or drug addict parents constitute a highly undesirable model for the child. Thus children of substance abusers may have a special problems in learning who they are, what is expected of them and what to esteem in others. Further, their range of coping techniques is likely to be more limited than that of average child.

1.6 FEELING OF INSECURITY

The concept of security is closely related with the feelings of being at home, safety, friendliness, calm, easy, relaxation, not conflicted, emotional stability, self acceptance and well based self-feeling of security strength. A person who feels himself secured must have tendency to accept other human beings, which refers to cooperativeness, kindness, sympathy, and sociability. Thus insecurity may be defined as emotional instability, feeling of anxiety, inferiority, rejection, isolation, jealousy, hostility, irritability, inconsistency and tendency to accept the worst general pessimism or sorrow. An insecure person always feels disturbed due to various self-esteem complexes. They show more neurotic and psychotic tendencies as compared to secured individual.
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According to Bruce (2008) security is both a feeling and a reality. And they're not the same. For some insecurity stems from having a fatalistic attitude towards life. We feel that the world and our environment are unsupportive or even hostile. We have found that many folks have a fear or terror of speaking out which is linked to a sense that in a past life they were tormented or tortured for doing so. We feel insecure because we are afraid of our own, or someone else's, erratic behavior. Sometimes insecurity results from feeling of victimized by powerful emotions. It is the type of emotional reaction that is out of proportion to a situation. For some people, insecurity stems from having felt abruptly disconnected from parental support, resulting in the feeling that one can't take care of or nurture himself. Such types of situation induce a deep feeling of insecurity. Thus a person is unable to deal emotionally charged issues feel insecure. An individual may found a reasonable sense of security in his life and is relatively self-confident. But what happens when a big change or transition happens? When something familiar like a job or a relationship ends, it's amazing how disorienting it can be. When you move or a loved one dies your sense of security may change dramatically. Once we let go of something there is usually a time during which the old is gone and the new is not yet born. Some of our most intense feelings of insecurity may rise during this time.

According to Maslow (1970), needs exist in a hierarchy. Only when lower-order needs are satisfied can higher-order needs be activated and serve as source of motivation. Maslow, places physiological needs such as those for food, water, oxygen and sleep at the base of the hierarchy of needs. One step
above these are safety needs: needs for feeling safe and secure in one’s life. This is second in the hierarchy of motives. When physiological needs are fulfilled, there emerges a new set of drives or needs, which is stated as safety an security needs. Human beings need safety for self and their belongings. These needs include security, stability, dependency, protection, freedom from fear and anxiety. Although each individual has his or her own perception of security risks, most people are usually able to deal with the insecurities they face. They develop personal security strategies or work with others to address those issues that concern them most. The two criteria to determine factors that undermine a person’s sense of security are: 1) People’s own declared threats to their sense of security, compared among different groups. 2) Anxiety symptoms among people living under different conditions. High anxiety symptoms are the most direct manifestations of a sense of insecurity.

According to Shah (1989), every human being has troubles in life but they react to them differently. Any problem that may disturb an individual might not be of any importance to any other individual. This develops the feeling of ‘insecurity and security’ among people which influences significantly in shaping and reshaping the personality of an individual. It also the mental health of an individual concerned, states that security can be defined as: “The condition of being in safety or free from threat of danger to one’s life or in which power or conquest is attained without struggle.” This is closely related to the feeling of being at home, safety, friendliness, calm, easy, relaxational, unconflicted, emotional stability, self acceptance, and well based
self-feeling of security strength. Thus, insecurity may be defined as emotional instability, feelings of anxiety, feelings of inferiority Shah (1989), rejection, isolation, jealousy, irritability, inconsistency and tendency to accept the worst general pessimism or sorrow.

NIDA (2008) while many events and cultural factors affect drug abuse trends, when youths perceive drug abuse as harmful, they reduce their level of abuse. This means that false sense of security that they feel while using drugs in the presence of their peers is the reason why they continue taking drugs.

According to Floyd & Garrett (2009), one may become psychologically dependent upon anything from a security blanket to another person to a pharmacologically inactive placebo (sugar pill). For whatever reason, the psychologically dependent person believes that he cannot do without whatever it is that he happens to be dependent upon. Thus any threat of loss or separation from the object of his dependence will arouse anxiety and trigger activity intended to prevent loss of the object. In this sense, substance dependence invariably includes psychological dependence upon the substance - but psychological dependence may be present without substance dependence or abuse.

According to Wilson (1995), when a person uses a drug, something happens in the body. The agents of the drug create a desired effect to a greater or lesser degree. In a person who has a proclivity to addiction, the first time that a mind or mood altering drug is administered to the body, this effect happens to such a degree that the experience can be that mythic "fix" that
changes everything. Drugs are used to change the way we feel, to the addicted person they become the solution to problems and have the ability to create a false sense of security and well-being. The person usually enters into this dangerous affliction because they attempt to compensate for some personal deficiency or life situation. Wilson (1995), states that addicts, even though often times are very capable individuals, have a low self esteem. They are depressed, unhappy or incapable of dealing with their life situations. It could be as simple as the rejection of a significant other, the loss of a loved one, or as complex as a major life crisis. This causes the person to seek "help" in the form of drugs or alcohol. Thus, the cycle of addiction begins. Therefore, feelings of security-insecurity, was considered as one of important variable contributing to drug abuse and hence was used in the present study.

1.7 APPROVAL MOTIVE

All human behaviour arises in response to some forms of internal (physiological) or external (environmental) stimulation. These behaviors are purposeful or goal directed. These behaviors are the result of the arousal of certain motives. Thus motivation can be defined as the process of activating, maintaining and directing behaviour toward a particular goal. The process is terminated after the desired goal is obtained. The process of initiating action in the organism is technically called motivation. Motivation refers to a state that directs the Behaviour of the individual towards certain goals. Motivation is not directly observable, but it can be inferred from occurrence if certain behaviour in a particular situation. Motive or motivation is now the most frequently used
and accepted terms in psychology to refer to the basic causes which move or activate the organism. An important characteristic of motives is that we never observe them directly. We infer the presence of motivation when we see that people work toward certain goals. For example, we might observe that a student works hard at almost every task that comes to him/her: from this we infer that he has the motive to achieve. But if we want to be reasonably sure that our inferences about achievement motivation is correct, we must make enough observations of the student’s” Behaviour to rule out other possible motives.

We are not aware of all our motives. Behaviour can be governed by unconscious motives also. We explain our everyday behaviour in terms of motives. Why do you go to college? The answer usually is given in, terms of your motivation. You are there because you want to lean; you need a degree to get a job: also because it is a good place to make friends. You may be in college because you think it is, expected of you .You are in college in response to one or more of these needs. Someone who understands your motives, understands why you do the things you do. Motives also help us make predictions about behaviour. We infer a group of person’s Behaviour. If this information is correct, we are in good position to make predictions about what person will do in future. A person who seeks to hurt others will express hostility in many different situations. A person who needs the company of others will seek it in many ways and situations. Thus, motives may not tell exactly what will happen but they give us an idea about range of things a
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person will do. A person with a need to achieve will work hard in school, in play, in business and in many other situations. Thus, motives are general states that enable us to make predictions about Behaviour in many different situations.

The needs may be broadly categorized as, primary basic or physiological needs and secondary or social needs. Need for food, water, sex, sleep and rest, elimination are primary needs. Need for achievement, affiliation, power are social needs. Drive is a force that compels the individual to act in a certain way to gratify the needs. When need arises this force becomes active and compels the individual to satisfy the needs without taking care of anything else.

Tripathi & Tripathi (1981) after receiving literature on approval motives, gave 7 tentative area along which behaviors are indicative of motive occur.

1. Normative behaviour: This area deals with behavioral 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 behaviors. These norms define the course of action prescribed, hence distinguish approved behaviors from non-approved one’s. In a study of social approval Goffman (1971) reported that self presentations are governed strongly by societal 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 presentations, 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 behavior, but indeed come to expect it. Normative behaviors are useful in gaining approval. Norms ensure regularity in human behavior, so that people need no worry about a wide range of things. Norms provide useful social service, norms serve as substitutes for indirect social influence (Horton, Marlow & Crowne 1963; Jenkins. 1960).

2. Social conformity: Although from a surface point of view conformity appears to be a constituent of norms it does differ from norms in at least one crucial respect i.e. it refers to imitative behaviors which emanate from concern of belongingness to one's social group. It does not involve deviation from or compliance with some social standard. A conforming behavior does not necessarily involve following of social norms. In a sense, conforming behavior is a less stable form of normative behavior. Social conformity refers to a person's changing his or her behavior to fit with the expectations or demands of others. In fact most of the time, groups or individuals make these expectations clear or the demands salient, ordinarily, one thinks of conformity as involving the persons being 'made' to do something he or she did not previously want to do (Asch 1952, Marlowe & Crowne 1961; Strickland & Crowne 1962).
3. Positive self presentation: It refers to the content of self disclosure to other people. While both verbal and non-verbal behaviors 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 the information. There is reason to believe that these dimensions serve different functions in self presentation behavior. Self disclosure or intimacy behavior 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, whereas saying positive things often gains approval from others. There is no necessary suggestion that because a person tells intimate details of his or her life, that person wants to build trust or that if the person provides positive self descriptions, he or she is trying to win social approval. Under a wide variety of circumstances, self-disclosure in fact leads to trust and positive self presentations 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 (Schneidez & Turkat 1975). Positive self-descriptions contribute to development of relationship. Although self-presentation helps not only in development of relationships, but can also be used to exploit relationships.
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Positive self presentations have 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 behavior are more likely to gain approval than other forms of behavior. The fact that these ways of gaining approval are widely known means, among other things can be exploited by any persons who chooses to use them in an unscrupulous way. Under the circumstances, then people may be motivated to cheat on the normative system. that is, they may be inclined to try to get approval through self-misrepresentation.

4. Defensiveness: 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 behaviors. 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. The area of defensiveness of the AMS relates to this aspect of social behavior (Barthel & Crowne 1962; McGinnies 1949; Crowne & Marlowe 1964).

5. Dependency: The inherent inability to function independently at the time of birth makes us dependent organisms. As a consequence functioning within the framework of environmental demands and to cope with such demands; one
is bound to become dependent on individuals and social groups of various kinds. In the course of social learning dependence in itself becomes a source of gratification. Eventually one likes to depend on others, though there are wide individual differences in this tendency. An individual with motive to seek approval perceives this reality, and probably has tendency to evaluate it in a positive manner (Schneider 1969).

6. Social responsiveness: The dimension of responsiveness has physical as well as social dimensions along which individuals differ. Studies 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 extraversion/introversion does imply such difference but it is loaded with surplus meaning. In the present context social responsiveness refers to individual’s tendency to respond to social stimuli in high frequency and magnitude In social situations he tends to react and sometimes over-react to social stimuli (Crowne & Strickland, 1961; Marlowe, 1962).

7. Social approval: It refers to active approval seeking from the agents of social reinforcement, because for approval motivated persons it is an important incentive. The behavioral tendencies implied in active 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 individuals, groups, or any other social organization which is perceived directly or indirectly by the individual as socially desirable.
Alam (1986) originally developed the concept of Approval motive and determine the differential effect of approval motive and dependence proneness on retention indicates that a person with a high need for approval is influenceable, credulous, and quite dependent on others for cues. His approval seeking leads him to be conforming and responsive to minimal social reinforcement. He is cautious, defensive, and easily threatened. This defensiveness is apparently due to anticipated threats to his already low self-esteem. The concept of approval motive was developed within the frame work of social learning theory and its was considered as a need potential. But the approval motive concept was reconceptualized and advanced who found that high approval subjects are externally controlled whereas low approval subjects are more internally controlled. In a series of studies, it has been reported that individuals having the strong approval motive are cognitively simple, easily conditionable in verbal conditioning, display external orientation, show social dependence as compared to their low approval motivated counterparts. It has also been observed that individuals with a high need for approval are field-dependent. Field-dependence is considered to be a lower developmental level than field-independence. Since the high need approval motivated individuals are field-dependent, they are developmentally lower than weaker approval motivation.
1.8 RATIONALE OF THE STUDY

The problems of drug addictions have become a threat all over the world and have been the focus of numerous studies in recent years. It has been reported that use of drug may interfere with normal cognitive, emotional, and social development.

A large body of research has also shown that Home-Environment has greatest effect on drug use. "Family conflict, family bonding and peer’s anti-social behavior are independent predictors of drug use. A strong feeling of rejection, hostility and helpless are the factors associated with drug dependency. Dhillon & Paawah (1981) reported that drug abusers are emotionally insecure when compared with normal subject Preeti & Priyanka (2006) reported that drug addicts carry the mindset of rejection by their parents, relatives and the society at large. However, a family bonding may sway the child to associate with peers engaged in more positive behavior (Guo, Hill. Hawkins, Catalaro & Abott, 2002).

The present study is designed slightly different from previous studies in order to understand drug addiction within a realistic framework by taking account of variables such as perceived Home-Environment, feeling insecurity and approval motives. Earlier researches as well as available studies have not much focus on these variables. Therefore, the present investigation helps in understanding the debilitating impact of pathological Home Environment along with feeling of insecurity and approval motives on drug addiction. The factors
of age in this context will also provide a holistic pictures about the problems of drug addiction.

1.9 AIMS AND OBJECTIVES

The aims and objectives of the study were:

1. To assess and compare Perceived Home Environment of Drug Addicts and Normal individuals.
2. To assess and compare Feeling of Insecurity of Drug Addicts and Normal individuals.
3. To assess and compare Approval Motives of Drug Addicts and Normal individuals.
4. To find out significant predictors for prediction of drug addiction.

1.10 RESEARCH PROBLEM AND QUESTIONS

1. Are there any significant differences between the mean scores of home environment and its subscales with consideration of age group, amongst drug addicts and normal individuals?
2. Are there any significant differences between the mean scores of security-insecurity and its subscales with consideration of age group, amongst drug addicts and normal individuals?
3. Are there any significant differences between the mean scores of approval motives and its subscales with consideration of age group, amongst drug addicts and normal individuals?
1.11 HYPOTHESES

Present investigation is undertaken to investigate the impact of home environment, feeling of insecurity and approval motive of drug addicts and also to compare drug addicts with those of the normal individuals with respect to ten important dimensions of home environment, eight areas of security-insecurity and seven potential dimensions of approval seeking. Therefore, in order to accomplish these main objectives, three main hypotheses were formulated for present study: Three main hypothesis of the study can be listed as follows:

1. There are significant differences between Drug Addicts and Normal individuals with respect to all ten dimensions of Perceived Home Environment, e.g.

   (1) Control,
   (2) Protectiveness,
   (3) Punishment,
   (4) Conformity,
   (5) Social Isolation,
   (6) Reward,
   (7) Deprivation of Privileges,
   (8) Nurturance,
   (9) Rejection, and
   (10) Permissiveness Score.
2. There are significant differences between Drug Addicts and Normal individuals with respect to all eight areas of security-insecurity, e.g.

(1) Family security,
(2) School security,
(3) Security peer group,
(4) Study Context Security,
(5) Prospective Context Security,
(6) Test Context Security,
(7) Self-context Security and

3. There are significant differences between Drug Addicts and Normal individuals with respect to all seven dimensions of Approval Motives, e.g.

(1) Normative Behaviour,
(2) Social Conformity,
(3) Positive self presentation,
(4) Defensiveness,
(5) Dependency,
(6) Social responsiveness and
(7) Social approval.