CHAPTER VI

DISCUSSION

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As the world is marching into the new millennium it is a time of hope and expectation. It is a world overtaken by change where information technology has connected continents and revolutionized communications. India is a country caught at the crossroads of such change. With technologically advanced life in the city, the bulk of her population is illiterate in rural India without the fulfillment of basic needs. The inequalities are increasingly sharpening. Industrialisation, urbanisation and migration have led to the overgrowth, overcrowding of cities giving rise to several low-class neighbourhoods and slums.

With these changes, the disadvantaged sections in society are at a further loss when it comes to facing life. Disparity in education, occupation, income and styles of living brings to the fore, frustrations, dissatisfactions, hostility and violence among the youth. Lack of basic skills and a quality of life, affordable entertainment and constructive leisure colours their reactions and responses to the problems of life.

Changes in the society specifically affect the community and in turn the family (Sekar, 2000). Families are in a state of transition because of the new socio-economic order. Families are undergoing a drastic transformation in structure from joint to nuclear families and from an extended kin to a primary kin structure. However, the traditional joint family has not yet completely metamorphosed into primary kin nuclear units. The families though structurally tending to become nuclear, functionally often tend to maintain jointedness (Gore, 1968) and continuous family management (Gupta, 1978).

The changing nature of lifestyles, age-old traditions and values are clashing with more modern materialistic values. The lure of innovation and
change has drawn people imperceptibly increasing the pressures of everyday living. India today is a country viewed by several outside countries as a nation with tremendous potential. One of her strengths lies at the family level.

The stresses and strains of modern living have given rise to various medias like television, movies or leisure time pursuits outside the home in contrast to the earlier forms of leisure in terms of family interactions. For many men, alcohol has come to stay as a suitable relaxant.

In recent times drug abuse has also emerged as a modern phenomenon especially among the youth. While many use and abuse drugs and manage well in society there are several others who get addicted to these substances. Alcohol is a drug encouraged worldwide by tourism and trade so the social acceptance is more (WHO, 1993). Drug abuse with its rapid addictive potential, illicit nature and change in drug of abuse is less socially accepted and tolerated. Hard-core drugs like heroin, morphine, pethidine, fortvin and tidigesic with more serious implications have taken priority. This has widened the base of research studies to the study of addictive behaviours in general.

Addiction to drugs is not merely a problem of the individual. It has broad socio-cultural factors influencing its abuse, transcending usage in a particular local context. The high-risk behaviour associated with alcohol and drug abuse exposes the family and children to the HIV threat becoming a public health problem (Chaddha, 1996).

While the problem has macro-level consequences yet the day-to-day life of the dependent person impinges on the family, which bears the brunt of dealing with the various inconsistencies of the behaviour of the abusing or dependent
individual. Families of alcohol dependents have been extensively investigated in the causation of the condition and their role in managing the problem of the dependent person has begun to receive attention (Bennett and Wolin, 1990; Sher 1991). Further the role of the family in therapy (Steinglass, 1979), the recognition of alcoholism as a family disease (Jacob and Seilhamer, 1987; Seilhamer and Jacob, 1990) contributed to the involvement of families in therapy for alcohol and drug dependents.

In the Indian context, marriage is a very sacred relationship for many women. The family bonds being strong in India the dependent person is tolerated, given the culture of rarely deserting the spouse, especially males. Despite the stress of addiction on their lives the families carry on functioning.

The family defines the stressful situation it is encountering and this affects the way they perceive themselves and the world. Thus, it influences their coping, the resources they use and ultimately their response/adaptation to the stress. The coping of families has come under scrutiny only recently.

The role of social supports forms an integral component of coping leading to adaptation to the situation. This is seen in the perspective of the strengths within the family. The adaptation affects cohesion or emotional bonding members have towards one another. The cohesion and adaptation type achieved either facilitates or hinders the family climate projecting a healthy or pathological picture to the world.

The studies of families of substance abusers are few in the Indian context and deal more with the spouse's coping and interactions with substance abuse. The families are predominantly viewed from a negative rather than a positive role.
they play. Few studies focus on both drugs with most of them being institution based and very few in the community. Further, both substances have rarely been studied together or in comparison with a normative sample.

The objectives of the study focus on the background details of the substance abusers and non-users. It studies the stresses that are faced by the families over the course of a year and a lifetime. In facing these stresses over the course of one's life the families depict certain coping patterns.

These in combination influence the functioning of the families with and without a member abusing substance leading to its adaptation. The adaptation of the families of substance abusers, are then compared with families of non-users living in the same community.

To achieve these basic objectives the methodology of the study compared the adaptation of the families of substance abusers with families of non-users living in the same community.

The execution of the methodology was guided with the basic hypotheses that even non-user families do face stress due to the life events, especially in the preceding year, yet have a better cohesion. In terms of substance abusers the assumption was that as the intensity of the substance abuse profile escalates, the family cohesion becomes low leading to disengaged families. This in turn affects the family coping and relates directly to the family adaptability, which could be rigid.

The above hypotheses were specifically analysed and accepted based on the results portrayed in the earlier chapter. The same is discussed in conjunction with other research studies in the current chapter.
PROFILE OF SUBSTANCE ABUSERS

Kasimedu, the universe of the study is reported as one of the high prevalence areas of substance abuse. It is a low class neighbourhood dotted by many slums adjoining the vast coastline that determines the occupation of fishing and small-scale industries. It is also an area of Chennai known for the high prevalence of child labour. This is a factor that encourages school dropout and contributes to low levels of education and predominance of unskilled, semi-skilled jobs. The majority of the respondents resided in the tenements and narrow by-lanes.

The maritime population in Kasimedu is also prone to facing hardships, physically and climatically. The banning of usage of alcohol while at sea subtly encourages the use offshore in a heavier fashion. Culturally, the usage of a local drink sundisoru (rice-beer) was common as referred to historically since 1897-98 (Chopra and Chopra, 1933). Fisher-folk find it a suitable coolant after strenuous days at sea. This is the population considered for the study. Thirty each randomly selected families from this population with drug and alcohol dependence with a matched non-user group respectively were studied in detail.

The social profile reveals that the majority, belong to the fisherman community by caste. They were settlers for several years in that area and some were recent migrants. The alcohol and drug dependent groups revealed a higher composition of the fishing community, which is typical of seacoast slums. A small proportion of each group resided on the seashore. Those residing on the seashore lived in huts indicating a lower standard of living even within the slum area as compared to others who lived in small portions of houses or tenements.
The majority who resided in these tenements came from the substance users group with nuclear families in contrast to one third from joint families among the non-users. Resembling the national average the family size was less than six members for all the three groups (GOI, 1991). With most of the sample population being married, half the families were in the preschool and school age group in the family cycle stage. The association between pre-school and school age stage for families with an alcohol abuser has occurred invariably due to the fact that they maintain not only the marital dyad (Ranganathan, 1983) but also nurture the family as an institution. The local subculture being tolerant to alcohol use did not become an obstacle to marriage and made the spouses maintain the family. The GOI (1992) study confirms a similar pattern in terms of marital status.

In contrast to this the families of drug dependents are associated with the launching stage of the family life cycle, marking the stage of launching of youth into adulthood and maintaining a supportive home base. The higher prevalence of younger age groups among drug dependents indicates that almost half the population did not get married. Some dependents though married were separated from their wives.

The onset of the habit early in life precludes marriage for many. This is in relation to the nature of addiction and the type of drug abused. These families could have reached the stage of ‘all children gone’. Yet they were not able to attain it for reasons of keeping the young adult drug abuser with them. This is further substantiated by the fact that a good number of drug abusers lived with their elderly parents and sometimes with their elder siblings.
The normative pattern in the community as studied for the non-users was not similar to that of the alcohol and drug dependents. This family profile clearly highlights the impact of substance abuse on the drug dependent family affecting the very movement of the family into the different stages. This is confirmed by the personal profile, which revealed that the alcohol dependents belonged more to the older age group of 31 years and above.

The persons with drug dependence were mostly in the age group of 20-30 years. Non-users were distributed in both the age groups. The age variations are seen as the graduation from drug use to abuse occurs in a shorter span of time. Alcohol abuse in contrast takes longer. The study indicated the younger age group as the most affected, besides being the most productive age who were associated with drugs. Drug abuse is a male dominated phenomenon, though occasional use of alcohol among elderly women was observed in the area.

The difference in age profile of the alcohol and drug dependent is in consonance with the majority of other Indian research work. The earliest studies on prevalence of alcohol in the general population in India, Sethi and Manchanda (1977), Dube (1978), Singh (1979), Varma and Dang (1980), Mohan (1981) Singh (1989), indicate usage of alcohol at a younger age. Similarly area specific studies like the one carried out in Delhi revealed younger ages from 15-24 years from poorer sections of the society being involved (Dorabjee, 1996). The Ministry of Welfare in their countrywide study on drug abuse in 33 centres reported 15-35 years to be the vulnerable age for drug abuse (GOI, 1992).

The educational status of the whole group was not above high school. The substance abusers had higher rates of illiteracy and had not crossed primary
education. This can be seen in relation to their occupation where higher proportions of alcohol and drug dependents have been found in sea-related occupations as catamaran coolies, launch coolies and in fish business, as compared to non-users. Further, a slightly larger number was unemployed in these groups. The other workers were rickshaw pullers, cooks, labourers, tailors, one arrack seller and factory workers.

The educational status of the samples revealed mostly young and middle aged males of low educational levels in seasonal sea-related occupation. Given the nature of occupation and hailing from the fisherman community many alcohol and drug dependent individuals did not feel the need or relevance of education. Very often they were inducted young into the trade.

Occupational studies reveal maritime population as high risk for substance abuse. Factors such as long absence from home and family, loneliness and harsh climate as well as accepted drinking practices and tradition may play a significant role in the development of alcohol and drug abuse (WHO, 1993). This corroborates with the findings of the present study.

Several studies on occupational status in different parts of the country reveal unskilled, small businessmen, daily wage earners, school dropouts and the unemployed predominantly among drug dependents (GOI, 1992; Sarkar et al., 1993; Paul, 1996; Veeraraghavan and Rao, 1996; Chaddha, 1996). 

The family respondents in the alcohol dependent and non-user groups were married, as they were the spouses of the alcohol dependents and non-users. The higher number of unmarried persons among drug dependents was due to the age of initiation being very young, earlier onset, the intense nature of
abuse, visibility of the addiction in the local community and the refusal of the community to give a girl in marriage. In spite of this, certain individuals got married and even in this small sample four separations existed.

Maintaining the same trend as the dependents the family respondents of the alcohol and drug dependent groups had the majority who were illiterate and had not crossed primary school education among the three groups. The groups being less educated were not likely to appreciate the nature of addiction patterns setting in. This highlights the importance of education in relation to health and specifically social problems like drug and alcohol abuse (WHO, 1999).

Occupationally more than half the family respondents in the drug dependent group were workers. As many drug dependents were young and unmarried they lived with their families of origin and were dependent on their families.

The occupational status of the family respondents of the non-users and alcohol dependents had many resemblances. Predominantly they were housewives, whereas the spouses of the alcohol group were engaged in sea-related and other work. Similarly the non-users' spouses were all mostly in other employments as goldsmiths, auto-rickshaw drivers, electric wiremen, carpenters etc. The employment though not very lucrative, they were steady in going for employment.

In contrast the family respondent of the drug dependents had to take up work, as they had to depend on themselves rather than the dependent, as he was not a steady worker. Despite the higher income of the drug dependent, this group was also characterised by job irregularity, frequent job changes, unemployment,
jail sentences and unstable employment much more than the alcohol dependents. One person peddled drugs. Although the drug dependent had the potential to earn or earned, yet in reality his contribution to the family was minimal. The higher family income of drug dependents is because many were still part of their family of orientation and their mothers and siblings contributed to the family income.

Among the drug dependents, six spouses of the fifteen married drug dependents were working and four were earning more than the drug dependents. In nine cases where the spouses were unemployed the drug dependents were earning, though they did not give much to the family.

The occupational characteristics revealed that in the drug dependent group those earning above Rs. 4000/- were mostly in the fish business category as labourers, coolies, catamaran and launch coolies. However, the income given to the family was only Rs.50/- per day in most cases as expressed by the spouses.

In contrast the income of the alcohol dependent group was below Rs. 3000/- per month. However, only two persons were unemployed in the alcohol dependent group. With meagre financial resource support from the spouses how do the families cope up with their day-to-day necessities? The answer to the issue is seen in terms of support from the other family members, specifically the wife and the children.

The contribution from the wife in twelve families who were in fish and other business was about Rs. 2000 per month. Others who were mostly domestic maids earned a paltry sum of Rs. 200 - 900/- per month depending on
the number of houses they were employed in. In one family both parents were not working, but depended on their unmarried daughter. The seasonal nature of the fishing occupation, the limited hours of work provides a lot of free time to the people. This is very often spent in the company of friends and they drink and gamble. In the absence of employment, few people go in search of other jobs stating that they will not be called again for employment so the time is often spent idling. These factors build an environment conducive for substance abuse.

However, in comparison to alcohol the tolerance to drug addiction is lesser. In the current scenario with the banning of brewing of the cultural drink sundisoru the abuse has moved to local arrack and Indian Made Foreign Liquor.

The personal, familial, social and economic profile of the substance abusers and the non-users does show that this population lives in unsatisfactory living conditions with lack of basic amenities and recreational facilities. They grow up in a highly endemic area, specifically slum pockets near the seashore where anti social activities and drug peddling is common. This local cultural scenario could induce people to socialize into drug use. Yet a number of them are staying with their families.

This highlights the positive aspects of the Indian family system that acts as a major resource of support to individuals who get into the problem of abuse. The profile of the family of substance abusers having been portrayed let us examine the family history of substance abuse and its transmission to the individual and his pattern of abuse.
SUBSTANCE ABUSE PATTERN

Before presenting the substance abuse pattern in the individual is it the presence of family history or is it the socio-cultural milieu that led the person to use and abuse drug or alcohol? The results revealed that there is an association between family history and substance abuse. Further, the observation also reflected that the study population is backed by a traditional usage of *sundisoru*. With easy availability of substances from the social environment portrayed earlier and a high-risk population - these factors have combined to yield a high prevalence of substance abuse in the families of the respondents, (70%). Of these, families of drug dependents reported a higher level of alcohol and drug abuse indicating that multiple persons are addicted. Families of alcohol dependents predominantly had alcohol usage in the family. These findings corroborate with the observations of Sher (1991) who reported genetic vulnerability along with environmental factors being associated with a family history of alcoholism.

Supported by a strong family history the age at initiation shows 21.63 years as the mean for alcohol and 18.60 as the mean for drug abuse. Most studies have shown a younger age group being associated with drugs than alcohol. Most IDU's usually start at an early age of 15-20 (Kumar, 1997). Beginning early, the alcoholic beverages commonly abused were brandy, illicit arrack, whisky and rum. The commonly abused drugs were brown sugar; tidigesic and the poly drug combinations included both ganja and pills.

While brandy is available in the innumerable wine shops around the city and neighbourhood, illicit arrack is surreptitiously obtained and used. Monetary
economics often determines the use of arrack for many - which is the inevitable choice when one runs short of money or is not able to attain the assured kick with brandy. Arrack is cheaper and more can be drunk for the same cost. Illicit arrack is a means of livelihood for certain women in the neighbourhood.

Most of the men drink outside the home and few within the home. The company of co-workers and friends is often sought or they drink alone. Although wine shops sell liquor - places to drink are not legally provided except in certain star hotels that have licensed bars attached. So a secret room next to the shop often serves as the make shift bar and eatables are served within or outside.

Most of them even lack a seat so the individual is compelled to stand and have his drink hastily for fear of being apprehended. This influences the pattern of drinking with gulping increasing the tolerance levels faster, with health implications. The use of illicit arrack further bears the threat of tragedies and death due to lack of knowledge of the ingredients used to make the arrack. Heavily intoxicated, some individuals barely reach their homes alone or they fall on the wayside.

In comparison to the alcohol dependent group almost half the drug dependent group used a single substance predominantly, the obvious choice was tidigesic and then brown sugar. The remaining 53% abused multiple substances such as ‘tidi’ (tidigesic) combined with ganja and/or pills or brown sugar with ganja/pills.

Going into the reasons for initial use or back into the history of drug use only personal reasons emerged. Alcohol dependents related relaxation and the
majority reported family problems, body pain, selling of liquor and a combination of these reasons. For drug dependents primarily relaxation, peer pressure and other reasons such as family problems, body pain etc. were expressed. While the reasons given for drinking appear to be personal, observation of the environment shows that several factors exist which is conducive to drinking.

For 90%, friends played a major role in the initiation into substance abuse, as stated by the families of drug dependents. Similarly the place of initiation was associated with the drug dependent group, as the family knew it as seashore, street or burial ground. Whereas for alcohol dependents it was friends for 50% and many family respondents said they 'don't know' the person or place as their spouses had started the habit before marriage.

Families were aware of the multiple mode of intake for drug dependents such as injecting, chasing, swallowing and smoking. However, 77% of the family members did not know the reasons for the abuse of more than one drug. Alcohol dependents show higher mean years of usage as fifteen years and for drug dependents it was eleven years. The difference indicates that the groups differed and are not homogeneous. All alcohol dependents belonged to the older age group as compared to drug dependents.

Other studies corroborate some of the findings of this study with relation to the pattern of abuse. Drinking is engaged in for the convivial pleasure that surrounds it (Jessor et al., 1969). Alcohol is the favoured drug used by the majority around the world. It is often not perceived as a psychoactive beverage with its use socially sanctioned and promoted by legitimate industry and trade.
This is similar to the descriptions of free availability of liquor in the wine shops in and around the current study area.

Structural features such as co-worker accessibility, teamwork and on the job alcohol availability have also been found to enhance work related alcohol consumption (Fillmore, 1990). It has also been suggested that odd working hours or shifts are factors that pull in the same direction (Cosper, 1979) and is found to be true of the current researched maritime population and their environment back at shore.

Skog (1985), Abbey et al., (1993), observed that social pressure to drink and direct modelling of alcohol consumption by network members relate to increased alcohol consumption. Peer modelling of drinking behaviours also influences the development of internalised expectancies for alcohol effects (Briddel et al., 1980).

Drinking tends to transform negative feelings into positive feelings rather than reducing the negative effect. Hence, such positive expectations of an individual about alcohol and its consumption would interact with the degree of perceived stress and other coping responses to determine the extent of drinking (Marlatt et al., 1973).

In the current study the expectations were of relaxation, alleviation of body pain, to forget family problems and seem to reflect expectations influencing the habit. All the other factors hold good for the current setting too where very often the men drink with their friends outside and include work mates. Risk factor studies showed that adolescents with drug using friends are more likely to use drugs themselves than those who associate with non-users.
(Hawkins et al, 1992). More than two decades of research on adolescent drug use shows that peer influence is a prominent cause, if not the most important determinant among a complicated set of circumstances (Baumrind, Moselle, 1985). Bauman and Ernett (1996), after network analysis of peer groups concluded that peer groups were not as important as assumed.

Habit was the reason for continuing to take alcohol or drugs. Among other reasons quoted by them was the compulsion to use, avoidance of withdrawal, availability, peer pressure, pleasure and a combination of these. Studies have shown that when the individual drinks regularly and comes across alcohol related stimuli (alcohol glasses, bottle, bar and wine shop) either overtly or covertly he tends to develop attraction because of which the drinking behaviour is maintained and the problem of drinking starts. Alcohol related expectancies add to it. With further regular drinking he develops dependence and gradually develops withdrawal symptoms and to avoid it, he continues drinking. Inadequate reinforcement from significant others maintains problem drinking (Prasad Rao, 1995).

The sanction of a society may permit a person to drink while the interdiction by society may produce severe conflict in the individual (Hayman, 1966). The fisherman community has a culture of using substances such as sundisoru and abuse of liquor thus has a certain social sanction in the absence of freely available sundisoru. Thus we can infer the interweaving of several factors in the initiation and maintenance of alcohol addiction.

For almost half the alcohol dependents the financial sources was their own income. The multiple sources were their wives, employers, friends and
siblings from whom they borrowed. The drug dependents group showed more association than the alcohol group with the multiple financial sources. The financing is always a problem and it is a day-to-day affair. An expenditure of Rs. 93 for alcohol and Rs. 159 for drug dependents per day on an average is a high amount given that they are daily wage earners coupled with their poor work history. This further reflects the magnitude of financial implications.

The mean income for a month is only Rs.1786 and Rs.2761 for alcohol and drug dependents respectively. The average expenses clearly reveal the financial inadequacies that would impinge on the family. When they do not obtain money - they do also steal, pledge or sell articles or peddle drugs wherein certain addicts are not allowed into the homes or trusted with things in the house. So they create law and order problems within the home and outside, often getting caught.

The drug dependents are so different as compared to alcohol dependents that they clearly depict a certain sub-culture of using drugs. There is a definite trend and pattern of abuse despite its changing scenario in the city of Chennai. The transition from cannabis to brown sugar to tidigesic is intriguing.

The abuse of drugs involved single and multiple substances like, brown sugar/ tidigesic, in combination with ganja and/or pills. Smoking of cannabis and chasing of brown sugar takes place as drug users congregate at public toilets, seashore, friends' place and abandoned markets to shoot drugs. The person is preoccupied with procuring the drug and using it to cut his 'turks' (withdrawal symptoms).
The emergence of tidigesic abuse has given rise to fixing or injecting as the preferable mode of abuse for 63% bringing in its wake the threat of HIV infection due to the sharing of needles and injection kits. 'Cocktails' as the dangerous combination of drugs is referred to have escalated rates of overdose and death in this community. Besides, the complications of thrombosed veins, infection and lack of injecting sites is a common occurrence. Madras has more than 5000 IDU's and studies have confirmed similar findings in Chennai (Stimson, 1993, Kumar and Daniels, 1994).

In the other parts of India, the scene is not very different from the current set up. In India, injection drug use has been reported from Manipur, Madras, Punjab, Calcutta, Delhi and many other areas (Indian Council of Medical Research, 1992; Kumar and Daniels, 1994; Prakash, 1996; Wodak and Dejarlais, 1993; Malhotra et al., 1993; Naik et al., 1991; Sarkar et al., 1991, 1993; Times of India, 1995; Verma and Chavan, 1995).

Injection drug use is seen as a technological advancement over other administration routes, since it is a cost efficient method of drug intake. Factors affecting choice of drug frequency and route of administration include availability, economic reasons, personal choice, tolerance and peer pressure etc., (Kumar and Daniels, 1994; Malhotra et al., 1993).

Most injecting drug users were poly drug users and combined heroin or amphetamine with cannabis, alcohol and/or prescription drugs (Skretting, 1992). Thus the client profile of opioid users in India corroborates the findings of this study. Does this profile lead to any specific consequence? Indeed it affects the person and their family in a holistic manner.
CONSEQUENCES OF SUBSTANCE ABUSE

Consequences of Substance Abuse – Physical:

Prolonged abuse of substances takes its toll on the physical health problems as perceived by the family members in both groups is decreased appetite, weight loss, deterioration in health, ulcer/gastritis. Except for body pain and ulcer/gastritis that was significantly associated with alcohol dependents, the drug dependents had a higher percentage of physical problems. Although much younger, the drug dependents showed specific associations with weight loss, lack of concentration and jaundice.

The course of addiction clearly reveals the impact of the substance abused. With hard drugs, cocktails, frequent infections and jaundice and also existence of T.B. in many - the slow ebbing of the life of the dependent is visible. This is further highlighted under the health domain over the last one year of the presumptive stressful life events.

The existence of sexually transmitted diseases was not expressed, as family members are not aware in many instances of the sexual behaviour of their spouses or family members. So the extent of high-risk behaviour and its implications for HIV transmission might be present even if not clear.

While the consequences derived from the taking of legal and illegal drugs is a major health problem in all countries, their perceptions and harm varies according to the social structure and culture in the (legal and illegal) drugs phenomenon. Alcohol is often perceived as the least harmful drug for health and society. For older addicts medical complications resulting from prolonged drug use is common (Cushman, 1980). Commonest physical illnesses associated
with drug addiction are TB, Hepatitis B, C, HIV, STD, septicaemia, endocarditis, scabies, fungal infection, venereal warts etc., In the rapid assessment survey carried out at Delhi, in addition to health consequences listed above other blood borne infections abscesses, cellulites, gangrene, etc., were commonly reported (Dorabjee and Samson, 1999). In an attempt to reduce HIV transmission in IDU's Chennai, India, needle and syringe exchanges was established in 1999 even in Kasimedu area by an NGO. Similarly, sub lingual buprenorphine tablets substitute buprenorphine fixing. Varied changes in the society and community bring into question whether drinking, smoking, and chasing or fixing result only in physical consequences? They do affect other domains of the individual and their family as described below.

Consequences of Substance Abuse – Psychological:

In contrast to the physiological consequences, families were less expressive of the psychological consequences 'feeling ashamed' and attempted suicide was mentioned. The drug dependent group was associated with 'feeling ashamed' more than alcohol dependents. One fourth of alcohol dependents were suspicious - a pattern of suspicion probably due to alcoholic paranoia.

The role of intoxicants in suicidal behaviour has been frequently debated and elucidated theoretically and empirically in a number of studies. A large number of studies (Sundby, 1967; Tsuang, 1978; Robins, 1981; Black et al., 1985; Whitters et al., 1985; Grunewald et al., 1995; Murphy, 1988; Shaffer et al., 1992) have all proved the association between substance abuse and suicide lending support to the current study. These psychological consequences have a direct bearing on the social life of the families of substance abusers.
Consequences of Substance Abuse — Social:

The need to conceal the habit and difficulty in sustaining one's roles, leads to various deviant behaviours. The long duration of abuse had social consequences for both groups with lying, drug use related arrest and job irregularity showing high prevalence. The drug dependent group showed significant associations with loss of reputation, avoiding social contact, petty thefts and unemployment.

The alcohol and drug dependent groups showed no difference on lying, defaulting on debts, non-drug arrest, job irregularity, frequent job changes and unstable employment revealing that they are similar in the manifestation of these problems. Peddling of drugs is present among one-fifth of drug dependents to sustain their habit and has legal implications wherein they have been arrested and jailed. Socially, people get to recognise the drug dependent and it is not easy to obtain and hold the job, as they have to procure the drug and use it. Further, if they do not take it withdrawals set in or even if they do use it, they get euphoric and at times it interferes with work. Thus, peddling of drugs seems a viable occupation for taking care of the financial needs of their habit. This exposes several youngsters to the habit and can lure them easily. Describing drug users' income generating means Dorn et al., (1994) reported of drug dealing, prostitution and other crime related behaviour.

Inability to keep jobs was one of the main social consequences of drug abuse apart from other aspects like, ostracism from the community, alienation from the mainstream activities and loss of self worth. In the current study, families expressed shame and embarrassment but not social isolation. At a lower
income level families do not suffer such rejection probably because alcoholism is merely one more problem amongst the many they have to learn to live with (Ranganathan, 1983).

These consequences at the physical, psychological and social level together highlight the impact this habit has on the person over a long course of abuse. The medical nature of several of these consequences projects the role of treatment as a viable solution and as a respite or relief from this problem. To avail treatment the substance abuser or their families need to have knowledge about such facilities to cut short the pathways to correct care in their help seeking process. Early identification of the problem, immediate and appropriate help would reduce the burden of care among families and better prognosis and outcome among the persons with substance abuse problem.

HELP SEEKING PATTERN

The rapid onset and consequences of drug addiction clearly point out to the need for treatment and 90% have sought help as supported by the significant association between treatment and drug dependence. In contrast, only 30% of the alcohol dependents alone sought treatment. The drug dependents sought help from the hospital in comparison to the alcohol dependents who approached the general practitioners in the area. The family members of the alcohol dependents were not aware of where to approach for the stopping alcohol.

Compulsions of the family, poor health, shortage of drugs, desire to change are some of the reasons prompting entry into treatment. Apart from the routine stressful life events in the immediate past and lifetime, do the
consequences of substance abuse cause any stress to the family members? This was examined with a community representative sample devoid of substance use in them, as well as in the family.

STRESS AMONG FAMILIES OF SUBSTANCE ABUSERS

The background characteristics, the pattern of abuse of alcohol and drugs and their consequences highlight the severity of the problem and the emergence of a situation that has a stressful element associated. Alcohol has been understood both as a stress reliever initially and later as a stressor for the individual. However, the existence of alcohol and drug dependence coupled by the presence of other consequences and stresses has its own impact on the family and the way they deal with situations.

The overall total number of life events on the presumptive stressful life events scale over a lifetime, showed a significant difference between the groups with substance abuse showing more number of events for alcohol dependents (8.21) and for drug dependents (7.10) followed by non-users (5.80). However, on the individual domains no significant difference was seen. Further, the quantum of stress over a lifetime also showed no significant difference between the groups.

On the number of life events over a year and the stress over a year, the groups differed significantly on health and legal aspects. This concern for health has been articulated in the reasons for help seeking too. The drug dependents approached specialised services such as deaddiction centres more, whereas alcohol dependents approached general practitioners as they went for associated medical problems rather than to stop drinking. Among the consequences of
substance abuse, ulcer, jaundice, frequent infections, deterioration in health, weight loss has been quite marked reiterating the importance of this aspect for the family. On the legal aspect also the groups differed significantly with substance related and non-substance related consequences.

The substance abusers experience more number of life events in the legal area and perceive higher stress than non-users. Alcohol dependents might offset stress induced emotional distress by resorting to drink which in turn might lead to a further increase in negative life events. The current study finding that alcohol dependents experience more life change events (stress) when compared to normal cohorts is also corroborated by, Thankachan and Kothandaram (1993).

The pattern of stressful events reported by partners was that illicit users reported more stealing, damage to property, pressure for money, physical violence, threatening behaviour and their partner going missing, or spending long periods in bed, unpredictable mood changes and partners of licit users reporting more irritability (Velleman et al., 1993). With increased stresses among the families of substance abuser they do have of many needs.

Voicing specific needs the families of drug dependents clearly hoped their family member would stop abusing substances as shown by the significant association. In Velleman et al., (1993) study the respondents expressed their hopes and fears for their futures. They predominantly described a generally negative view, with some being pessimistic, others fatalistic, and others feeling vague, uncertain or ambivalent about the future. In the current study, many respondents were able to remain hopeful about the future, with some respondents feeling that they were survivors, and others that the family would continue
together or would regroup together again. Thus we see the families of substance abusers are a distinct group, whose reactions are coloured by consequences on the families of orientation and procreation.

In the family of procreation it was observed that awareness of use of substances by the husband was expressed by one-fourth of the spouses of alcohol dependents and 30% of drug dependents were aware before marriage. The families of drug dependents admitted that they did not know the magnitude of the condition or its development.

For alcohol dependents they thought it will be social drinking and for most of them heavy drinking started after marriage. Alcohol being a progressive disease the effect is not seen early in life. Quite often the woman finds out about the husband's problem only after it reaches the stage of excessive drinking or when his health noticeably breaks down (Ranganathan, 1983). The graduation from substance use to heavy use or abuse makes a difference in the initial and current reaction between the family members of alcohol and drug abusers.

The initial reaction of the parents and the spouses to alcohol abuse was milder than for drug abuse. Alcohol being more culturally accepted, not socially prohibitive, with a longer duration of dependence and being so occupationally related probably proved less fearful. The majority expressed that family relations were good before use, so also for drug dependents. However, 82% in both the groups reported family relations being affected after use/dependence. This is in keeping with other studies (Rossow, 1993).

Problem behaviours reported were failure in task functioning, failure in giving up the habit, argumentative, aggressive behaviour, neglect of health and
financial difficulties. The current reaction of parents to alcohol abuse was indifference, whereas for drug dependence they had resigned to it, felt helpless and angry. Many of the parents of alcohol dependents were not living with them, so the impact felt was lesser. Among the spouses, current reaction to drug dependence involved helplessness, indifference and anger to the situation and less of sadness and advice and a few left the drug dependent not perceiving change or a future with him.

Parents frequently described their realization that their son or daughter was using drugs as a tremendous crisis, causing fears of the child's death. Emotions such as shock, anger and guilt predominated. Partners were generally less shocked and surprised by the drug use (Velleman et al., 1993). Though families describe this as a tremendous ongoing stress, how do they cope?

FAMILY COPING

The responses, reactions, perceptions all affect the way the families will cope with the problem. The family coping patterns in response to the crisis of substance abuse and other problems as revealed by the stresses faced over a lifetime and a year are described.

The total family coping reveals a higher coping ability in families of non-users followed by drug and alcohol dependents. This difference is statistically significant. The total number of lifetime events, which reflect the same progression, supports this. Thus families of alcohol dependents seem to be more stressed - probably because of longer duration of the problem.
Stress is chronic where many have not sought treatment for stopping drinking and they have family histories of substance abuse characterized by frequent conflicts, violence, role failure, and health problems. Going into the specific domains of coping, except in acquiring social support and mobilising family to acquire and accept help, the families of alcohol dependents have slightly lower or the same mean as the other two groups.

The drug dependents' group has consistently lower levels of coping than non-users in all instances except in mobilising family to acquire and accept help. The families of drug dependents were more aware of groups helping drug dependents as shown by the significant association but the participation in self-help groups such as Al-Anon or family support groups was negligible.

Awareness of welfare agencies was also higher among drug dependent families and showed a significant association as they received help from them. The local agency 'Sangamam', TTK hospital, Sri Ramachandra Hospital, Institute of Mental Health, Stanley Hospital were all approached for help predominantly by the drug dependents.

They were also aware of community help for problems like fire accidents, obtaining ration card, loan etc. A study among relatives of drug dependents revealed most family members had some sort of support available to them, and many had more than one form of support (Velleman et al., 1993).

The impact on the family of orientation for alcohol dependents is lesser given that most of them are married and live with their spouses. For drug dependents all the consequences are higher. There is a significant association between drug dependent group and poor familial relations, loss of trust/respect.
and inadequate financial contribution. Violence and frequent conflicts are only present in this group's family of orientation and it is coupled with demands for money.

In keeping with the current study findings considerable evidence suggests that substance use contributes to violent acts (Watts and Wright, 1990). The relationship between alcohol and criminal behaviour is highly complex. However, Jaffe et al., (1988), Franklin et al., (1992); Bradford et al., (1992) found that alcohol was related to aggression and violence.

These aspects coupled with the physical, psychological and social consequences have an impact on the families' response to the dependent person. The failure in giving up the habit by the dependent individual despite treatment leads to family discernment that the problem rests with their family member.

Among the families of procreation, frequent conflicts, role failure and violence characterized the families of procreation of alcohol dependents. The drug dependent family was also associated with violence, role failure, loss of trust/respect and inadequate financial contribution. The drug dependent group's association with inadequate financial contribution was reflected by job irregularity, frequent job changes, unstable employment and unemployment. Given the seasonal nature of fishing occupation and low wages of unskilled jobs such a scenario can be highly frustrating for families. This shows that the roles of the members in these families as breadwinners, parents and siblings were affected. How do families cope up with such an extreme frustrating scenario?

A high percentage of separations were noted in the current study, more so among drug dependents to overcome such a scenario. Two or more
separations were common and were frequently abuse related. Four spouses of drug dependents had left their husbands not perceiving any change in them or a future. In the western context wives are more likely to seek and obtain separation from their alcoholic husbands the more they have been exposed to hardship or deviance within their marriages (Jackson, 1963; Cheek et al., 1971). Nonetheless the cohesiveness of many alcoholism-complicated marriages has surprised a number of observers (Jackson, 1963; Haberman, 1965). Marital assault has also been shown to have a high connection with alcohol consumption (Gondolf and Foster, 1991).

Many alcohol dependents were married yet the women rarely left their husband's despite the problem. This is because divorces are not encouraged in India. It is observed to be one of the tactics used by the wives of alcoholics (Bagadia et al., 1981; Ranganathan, 1983).

Wife beating is also a cause for further breakdown of marital relationships. In India, the amount of suffering the spouses underwent with their alcoholic husbands is enormous (Ranganathan, 1983). She reacts to her husband's alcoholism either by mutely accepting her 'fate' or by throwing tantrums, sulking, losing her temper or walking out on her husband for a brief while (Ranganathan, 1985). Research into the families of problem drinkers (Collins et al., 1990; Velleman, 1993), were remarkably similar with the violence, unpredictability and embarrassing behaviour.

Overall the impact of dependence is felt and perceived more by the families of drug dependents as compared to alcohol dependents, as the impact is faster and early. The family is frequently the first line of reaction to the
drinker's behaviour and family members often employ a variety of strategies to try to change the behaviour and sometimes to punish it. High levels of conflict have frequently been noted in other studies. The various sources of hardship include loss of family earnings, infidelity, and involvement with police, rowing and physical violence (Orford, 1975). In the current study the families of substance abusers when confronted with this situation in comparison with non-users had a higher need to acquire social support and mobilise the family to acquire and accept help which is part of the family's attempt to deal with the problem.

The higher levels of passive appraisal - ability to accept problematic issues, minimizing reactivity in families of non-users probably decreases it's necessity to mobilise family to acquire and accept help professionally as compared to alcohol and drug dependent families. This is supported further by their higher levels of coping on reframing and spiritual support indicating an overall better ability with a lower mean lifetime stress level as compared to the others.

There is also a certain philosophical element in passive appraisal, the belief that time will help certain things through. Culturally there is a belief in fate, timing in the Indian culture. While in the western context, this is a negative aspect of coping in the Indian context it is common to transfer problems to external fate making it more manageable. Similar appraisal in Indian culture has been reported (Banerjee, 1972; Sekar 1984; Karnik and Suri, 1995).
In a study on coping majority followed strategies, which were described as non-contentious or non-confrontative. Others described actions that were self-protective. Respondents also described actions that included being inconsistent, 'living from day to day' or 'living one step at a time', and hiding this problem from others (Orford et al., 1992).

The styles of coping behaviour used most by wives of alcoholics were discord, fearful withdrawal and avoidance. Competition was the least used style - there may be several rows and fights but the wife rarely coped by drinking herself or by pretending to be drunk. This is attributed to the cultural factors such as censure on women drinking and women's roles in India (Chakravarthy and Ranganathan, 1985).

Another rarely used style was marital breakdown. In the western context Jackson, (1954), James and Goldman (1971), Orford et al., (1975) also found that the behaviour of the wife changed according to the stage of drinking and hardship experienced by the wives. Jackson (1958) and James and Goldman (1971) observed that a progressively worsening situation offered no clear guidelines for coping behaviour. Wives were forced to evolve techniques of adjustment by a process of trial and error.

Wives of alcoholics use 'avoidance' as the most commonly endorsed coping behaviour. The Indian wives personality is that they are basically passive, timid, compared to their western counterparts. A significant percentage of women had endorsed assertive coping behaviours, i.e. many women had agreed that they tried to pay back the pecuniary debts of their husbands with help from their parents. Many spouses are forced to take monetary help from
their parents or seek low wage jobs to keep the family going. Many wives used fearful withdrawal. It occurs more if husbands become violent or abusive under the influence of alcohol (Chandrasekaran and Chitralekha, 1998)

An alcoholic fails to fulfil certain family roles and responsibilities such as those of parent, lover or provider. This results in more problems and wives use more number of coping strategies. The chosen method of coping may vary from one person to another depending on the effect of problem drinking or drug abuse and the degree of hardship. Ultimately the pattern of coping varies from person to person and family to family. This has its impact on the family functioning. What happens to cohesion and adaptability when considered in conjunction with the coping strategy?

FAMILY ADAPTABILITY

The family's response to stress as described in the above mentioned paragraphs might be conceived in terms of two phases as reported by Mc Cubbin and Patterson (1983). Phase one is more of disruption or crisis when the family comes to know about the problem with the family member. The second phase is of adaptation.

Cohesion:

In the face of stressful events and changes, some families may be more vulnerable and therefore experience more disruption in being cohesive. The significant differences among the three groups in the dimensions of emotional bonding, family boundaries, coalitions, time, friends, decision making, interests
and recreation indicates that they are different from each other. These differences were influenced by existence of substance abuse in the family with alcohol dependents showing a little better cohesion than drug dependent families. The overall cohesion depicted a significant difference between the three groups where in, the non-user families had highest mean score for cohesion within the family. Sher (1991) reported that alcoholic families had lower levels of family functioning such as cohesion in comparison to non-alcoholic control families.

Indication of higher existence of cohesive activity among the non-users family is inversely related to coalitions and family boundaries. This in turn reflects that the non-user families restricted discussing problems with outside members rather than their own family members. The family members did things together rather than going their own way. Stress due to life events in the past year and cohesion is inversely related. This shows that even the normal families do have higher number of life events and stress in the last year, which was related to lesser cohesion and cohesion type.

There is an inverse relationship between stress due to life events and cohesion among non-user families. This further raises the issue whether these families due to higher stress and lesser cohesion do have a negative adaptation. The correlation result reveals the opposite of the same. In spite of lesser cohesion, the families do have a better coping pattern and flexible adaptability. Thus adaptation becomes a process of the coping towards the stress than cohesion in the non-user family. Olson et al., (1984) report that too little cohesion is seen as dysfunctional to the family system. However, families able to balance between the two extremes seem to function more adequately.
In comparison, in families of substance abusers, boundaries and coalitions contributed to lesser cohesiveness. The individuals from substance abuser families were characterized by going their own way and do feel closer to people outside the family than within the family.

Space as a dimension did not reveal any difference among substance abusers and non-users as most of them lived in one room or two room residences, where family members did not have much choice but to be together. The physical infrastructure of the residences in this area is predominantly single room tenements. The non-availability of privacy in the family acts both as a barrier and facilitator in terms of development and sustenance of certain deviant behaviour among the family members.

Comparing between the two substance abuse groups, it is seen that emotional bonding is lower, coalitions are higher, time spent is lower, knowledge and approval of friends is lower and decision-making is not shared as much in families of drug dependents as compared to alcohol dependents. Only the means on family boundaries are similar.

Considering independent domains, emotional bonding refers to supportiveness and closeness among members. This is in contrast to coalitions, which reveals that in the family everyone goes his/her own way, members pair up to do things than as a total family. Between the two substance abuse groups emotional bonding is lower and coalitions are higher in drug dependent families indicating that they reflect less unity.

Another aspect of cohesion is time spent doing things together or spending free time with each other. The impact of this aspect is probably reflected in
decision-making too, such as consultation or going along with the decision. Alcohol dependent families spent more time together probably because they had more families of procreation i.e. married individuals and lesser single men than drug dependents. So they gave time to their families or the family members spent time with each other more.

The drug dependents' lifestyle being more unpredictable and very often absent from home, time spent is less, this is also reflected in the lesser involvement in decision-making. The drug dependents were very often preoccupied with their drug taking habit, so even if present they did not participate in decision-making or their families ever asked their opinion. Further, a significant proportion of drug dependents lived with their mothers only, who had to manage themselves financially and otherwise. In certain cases even if others were present the mother was the main decision maker.

The absence from home was accounted for by the time also spent with friends. Lower scores on friends reflected lesser knowledge about the substance abuse and approval of friends. The drug users' friends were also mostly drug dependent and a lot of time was spent in their company and they were not approved of. Even if they were treated the friends were quick to draw them back into the fold. The peer influence on drug addiction and maintenance has been reported throughout the country in the GOI study (1992).

Cohesion Type:

Classifying all the families according to cohesion type, it is seen that 49% of the families were disengaged. These families had very little closeness between each other and were more individualistic. Due to the individualistic attribute
they were independent and lacked loyalty and were separated. One among every ten families studied were characterized with more emphasis on the individual and less on the relationship, levels of closeness were often low to moderate in the separated family system. These members were more independent than dependent and showed more separateness than togetherness.

A similar proportion was seen with higher characteristics to the above category and had more representations from the non-users family. In yet another one third of the families there was more emphasis on being together, less on separateness as discussed above. There is some loyalty to the relationship and there is more dependence than independence. These 'connected' families were more among non-users followed by alcohol and drug dependent families. Viewed specifically more than two thirds of the families with drug abusers (77%) and alcohol dependent families (63%) contributed to disengaged families. Fishman et al., (1982) reports of situations in working with adolescent drug abuse families before treatment as being not cohesive and not working together as a unit.

Disengagement refers to extreme low cohesion among these families, as supported by lower cohesion scores. Disengaged relationships emphasize the individual. There is often very little closeness, a lack of loyalty, high independence and high separateness.

The remaining one-fourth drug dependent families showed balanced level of cohesion and were separated and connected. The alcohol dependent families also showed balanced levels of cohesion, but more connected 20% than separated families 10% indicating higher levels of balanced cohesion as compared to drug
dependents. A small percentage was very connected 7%, indicating extreme high cohesion - which was totally absent in drug dependent families.

The correlation co-efficient for alcohol and drug dependents separately and combined as substance abusers with family cohesion did not yield any significant relations. Thus cohesion is seen as an independent factor not influenced by the substance abuse profile. In contrast the non-users revealed extreme low to extreme high cohesion levels. Few families were disengaged 7%, a little higher percentage was separated 10%, with the majority connected (57%) and a little more than one-fourth was very connected. No other correlation for non-user families was seen for cohesion with other variables than stress.

Very connected/enmeshed emphasize togetherness, very high levels of closeness, loyalty and dependence on each other. Expression of disagreement, and independent thoughts and feelings are not tolerated. These results reflect that families without substance abuse were definitely more cohesive in this locality despite facing similar life conditions and stresses. Their higher coping levels probably influenced better cohesion levels.

Adaptability:

The family adaptability reveals the total adaptability to be highest for non-users followed by drug and alcohol dependents. The groups differed significantly indicating a better ability to change power structures, role relationships and relationship rules in response to situational and developmental stress in families of non-users as compared to families with substance abuse.

On discipline, negotiation and rules, the groups were different. The aspect of discipline deals with fairness of discipline and whether children had a say in
their discipline. The higher mean scores for drug dependents in this domain does reflect the non-disciplinarian child rearing practices at early stages and non-control by the family during the later part of the life. Higher mean scores on rules indicate lesser flexibility in rule change or knowledge of existence of rules in families of alcohol and then drug dependents as compared to non-users.

Negotiation referring to problem solving skill was higher among families of non-users than drug and alcohol dependents. Non-users discussed the problems, felt good about the solutions, tried new ways or compromised. Reiss (1981) intensive experimental studies rely heavily on the problem solving skill among families and reported that it facilitates movement of families to change (adaptability).

On leadership all the groups were alike - every family member has input regarding major family decisions. In solving problems the children's suggestions are followed. More or less similar mean scores of all three groups showed that similar leadership patterns were present.

In solving problems children's suggestions are followed, was not applicable in many instances as many of them had children below 12 years. Further, when they are female children, they are often not consulted, only the head of the household decides. Similarly, on discipline, children do not have a say ultimately, in the Indian context. They abide by the parents' decision. Similarly, in assertiveness the families are alike with regard to what they can say, what's on their mind and they express their opinions. Similar observations are seen in Garg and Parikh (1976) and Mahale's study in Indian situation.
All groups had similar role functioning. The items dealt with were shifting of household responsibilities from person to person and sharing of responsibilities. Although leadership and roles reflect homogeneity in groups, yet on negotiation (problem-solving) they differed where it was lower in families of substance abusers. Discipline and rules in the family seemed to vary. The groups with substance abuse did not seem to have proper functioning, although leadership existed. Studies by Callan and Jackson (1986) and Benson and Heller (1987) support this finding.

Between the substance abuse groups, adaptability was lower in families of alcohol dependents, indicating lesser flexibility or adaptability to change its power structures, rule relationships and relationship rules in response to situational and developmental stress as compared to families of drug dependents. Sher (1991) reported similar findings of lower level functioning among families with alcohol abuser in comparison with non-alcoholic control families.

Sethi's (1989) observation for Indian families on the decision-making power holds true for the current study. In the areas of cohesion and differentiation the traditional Indian family places heavy emphasis on proper attitude and conduct in accordance with the prescribed roles, obligations and duties. The Indian family seeks ideological uniformity and the group pressure of conformity results in non-expression of individual disagreements against the majority opinion.

In the Indian family the emphasis on boundaries seems to be more between family members and outsiders (boundaries diffused not really problematic). In the area of communication Indian families often utilise subtle
indirect ways to express feelings and reveal information usually suppressing critical comments and negative emotions. The Indian family encourages mutual dependence and collaterality, hierarchy, compromise and is held responsible for the individual family members' behaviour.

**Adaptability Type:**

The adaptability type of the three groups revealed that almost 50% of the families were 'rigid', followed by 'structured and flexible families' none of the families were 'very flexible'. Viewing the groups individually, two-thirds of alcohol dependent families were rigid and the remaining one-third structured. None of these families were flexible as corroborated by their lower adaptability scores.

Families with an alcoholic member are characterized by a variety of structural dysfunctions, including chaotic or rigid patterns of adaptability (Steinglass 1975, Anderson and Henderson, 1983; Lawson, Peterson and Lawson, 1983) and disturbed interactional boundaries (Anderson and Henderson, 1983; Bepko and Krestan, 1985; Seixas and Youcha, 1985; Wegscheider, 1981). The rigid patterns result in difficulty in coping with stress (Olson et al., 1979). Rigid stability characterizes dysfunctional families.

Steinglass et al (1979) state ‘alcoholic families are significantly different from their non-alcoholic counterparts' in cohesion, level of conflict and problem solving style. Further, he presented the hypothesis of adaptive consequences of alcohol use that are sufficiently reinforcing to maintain drinking patterns.

In the drug dependent group, a little more than half the families, were rigid (57%); whereas the others were structured (23%) and flexible (20%)
reflecting better adaptability than alcoholic families. The non-users showed better balance in having the majority as structured and the remaining rigid (23%) and flexible (20%). None of the families were 'very flexible' in any of the groups, indicating extremely high degree of change. This implies whether substance abuse is present or not, families were not totally chaotic, they do have organisation characterised more by rigidity. Rigid families indicate a very low degree of change. They continue to use the same ways of solving problems despite the changes in the surroundings. This extreme level appears as unbalanced and problematic, as families are stuck at these levels. In rigid relationships, there is little change and leadership is authoritarian; as a result, discipline is strict and roles are very stable and seldom change; negotiation is limited.

It is said, families by nature tend to resist change, as they are basically rigid. Most families, function primarily to maintain status quo. When an organisation indicates a change in relation to another, the other will act upon the first so as to diminish and modify the change (Haley 1964). In short, when one partner tries to make changes in a relationship, the other partner’s first reaction is often to defend against the change or at least to slow it down until he or she can better understand what is happening. People often fear that the change will bring more harm than good. The family, which is maintenance oriented and conservative in its approach to change, often creates even more problems for itself. Families that rigidly try to maintain homeostasis through successive developmental phases are highly disturbed and atypical. Enduring success in
maintaining family homeostasis perhaps should be regarded as a distinctive feature of disorder in families (Wynne, 1958).

Extreme stability is seen in rigid families than those in which there is little room for change. The family rules are always the same, even though the game of life outside the family continuously changes. The majority of substance abuse families being rigid as compared to non-users indicate that these families are extremely unbalanced and have problems. More members of alcoholic families are rigid indicating that they try to resist change and maintain status quo. In the face of continuing alcoholism and upsets in family life, the family seeks to find stability. The lack of treatment or abstinence among most of them has led to the chronicity of the problem.

The remaining one third, are structured which is one of the two balanced levels of change. It is these two levels that have a good balance between stability and change. Structured relationships have more moderate levels of change, with leadership, that is sometimes shared. Discipline is often democratic and roles are stable. Discussion on negotiation is organised, the rules are clear and stable. None of the alcohol dependent families are 'flexible' - which means none of them have democratic functioning or role sharing. It is the higher level of balanced change. Thus, the adaptability of alcohol dependent families is lower as compared to the other two groups.

Research has also shown that families of alcoholics are more rigid, have lower levels of cohesion and expressiveness, have less recreational orientation and experience more conflicts than do non-alcoholic families (Bromet and Moos, 1977; Moos et al., 1979; Billings et al., 1979; Jacob et al., 1981).
The drug dependent families are predominantly rigid (57%), some were structured (23%) and a few being flexible (20%). In flexible families leadership is often shared, discipline is democratic, negotiation involves open discussion, there is role sharing, rules are clear and flexible and there is some change.

On the Circumplex Model, the family types of the three groups revealed thirty-nine percent of the families are extreme in functioning - indicating extremes in both dimensions. Among the rest, 24% of the families indicated mid-range type, 32% were moderately balanced. Only four percent of the families are balanced. Taken individually, the groups of alcohol dependents show more extreme families followed by mid-range type. None of them were balanced.

The drug dependent families showed a little more than half the population as extreme type, mid-range 40% and balanced 7%. The nonusers were concentrated in the mid-range type with majority being moderately balanced (63.3%), mid-range 27% and a few balanced families (6.7%). A negligible percentage was extreme. This distribution reflects the contrast between alcohol families and non-users families more, followed by drug dependent families.

Family adaptability among substance abusers:

Considering the two groups on both aspects taken together the four levels of cohesion are disengaged, separated, connected, (cohesive) and very connected (enmeshed). The total cohesion scores of alcohol dependent families were lower
than the non-user families, but higher than drug dependent families indicating better emotional bonding.

The families are more cohesive though adaptability is lower. The cohesion stemming from the levels of change in the overall functioning of the family gives it certain stability. This is probably due to the changing nature of alcohol dependents and changes in lifestyle, that the family tries to maintain stability and foster cohesion to keep the family intact.

The situational context of the family has an impact as of the current study results. For instance Russell (1979) reports that the optimal level of family cohesion may be lower in crowded living conditions where the only means to privacy is a certain 'civil inattention'. Family routine may be more important when the external environment is unpredictable and uncontrollable. As a result, relatively lower levels of family cohesion and flexibility may be adaptive in many lower class settings.

Going by the cohesion type, three-fourths of drug dependents and almost two-thirds of alcohol dependents were disengaged, reflecting their cohesion scores. One fourth of drug dependent families were separated and connected and none were very connected - meaning that they were not enmeshed. The lower cohesion scores support this for the drug dependents as compared to alcohol dependents and non-users. Thus, these families were more adapting and changing but could not build emotional bonds and be cohesive. Among the drug dependents a good proportion still belonged to the families of orientation and they were unmarried and had siblings. When confronted by various changes and stresses of life coupled with substance abuse and its problems impinging on them
they probably tried to adapt to the change, but could not build the bonds or the
closeness was affected by the problem.

The cohesion scores, adaptability scores, cohesion type, adaptability type
gets reflected in the family type. Alcohol and drug dependent families show very
high levels of extreme families 60% and 53% indicating that these families have
extreme levels of cohesion and flexibility. Both groups have 40% in mid-range
type of families with drug dependents showing more mid-range and alcohol
dependents showing more moderately balanced but nil balanced families.
Whereas drug dependent families showed more spread in the balanced type with
few moderately balanced and few balanced families.

Families of non-users and families of drug dependents have better
communication skills than alcohol dependent families, which are not balanced
at all and were more extreme than the others. The non-user families showed a
concentration of 90% of mid-range types with the majority showing more
moderately balanced and few balanced families, negligible extreme families.
Taking together the dimensions of adaptability, cohesion and family type, the
non-user families do not have extreme levels of cohesion though a
representation is seen in the rigid category of the adaptability.

Studies on alcoholic families have revealed marital disruption disrupted
family rituals, poor cohesion, expressiveness and recreational orientation,
difficulties in communication and effective involvement and lack of clear
hierarchical boundaries (Suman and Nagalakshmi, 1995).

The fact that alcoholic families identified the most disturbances
 corresponds also with family therapy theory, which proposes that dysfunctional
families have difficulty with emotional bonding and individual autonomy (Minuchin, 1974; Olson et al., 1979). Enmeshment is believed to preclude autonomy while disengagement precludes interdependence (Minuchin, 1974). Both extremes are proposed to affect the family's ability to function effectively as a unit as well as to provide adequately for the need of members.

Alcoholic families frequently demonstrate dysfunction in emotional intimacy. It has been hypothesized that a relationship with alcohol replaces intimacy with another individual, with alcohol becoming a substitute object (Covington and Beckett, 1988).

In order to make the Circumplex Model culturally relevant to a variety of families with different ethnic and cultural backgrounds, a hypothesis was developed to reflect this diversity. The hypothesis states that if normative expectations of families support behaviour extreme on one or both of the dimensions, families will function well as long as all family members are satisfied with these expectations.

In this way, the family serves as its own norm base. One-fourth non-users were very connected/enmeshed. Enmeshment consists of a large range of family characteristics, many of which may be unrelated to degree of closeness. It takes the form of intolerance of certain forms of interaction. This includes intolerance of differences of opinions, of members exercising self-interest, of individual achievement, of bonding to outsiders and of keeping secrets from family members. When family members experience these behaviours as oppressive, they will most likely react with distancing behaviour and will not describe the
interaction as close. Those members who do not experience enmeshment as limiting, will rate their families as close and well functioning.

According to Olson et al (1985), functioning at the extremes is not detrimental unless family members experience it as such. The concept of enmeshment may still be a useful concept. It may help us understand how some families try to escape conflict and loss of closeness by limiting their own and others' thoughts and behaviours. This enmeshment reflects the normal functioning probably for these families and is not uncommon in the Indian culture.

Understanding the dynamics of the family interaction patterns we find that the shift has occurred in viewing these same dynamics not as indicators of just dysfunction but as strengths, which can be tapped. The concepts of cohesion and flexibility are similar to the concepts of commitment and time together - cohesion, ability to deal with stress and spiritual well-being is an element of flexibility and communication the third facilitating dimension is appreciation and affection for each other. The normative pattern of the community in the study area being established through nonuser families let us view the other two groups. The families of both the alcohol and drug dependents are seen at extreme levels on both the dimensions.

There is a moderate spread over in the mid range families for the alcohol dependents, wherein they are at the extreme on the dimension of cohesion but balanced on adaptability. This proves the final hypothesis of the study stating that the alcohol families are more rigid which is extreme low adaptability (67%) relating with disengaged which is extreme low cohesion (63%). Similarly,
families with drug abusers are more extreme on low cohesion by being disengaged (77%) and have lower adaptability by being rigid (57%).

Families go through different stages and at this point of time they reflect this position. It is possible that the situation has worsened depending on the condition of the substance abuser and the stresses they have faced especially health and legal aspects related most often to substance abuse. As the condition of substance abuse improves and their other stresses decrease or their coping becomes better the family might move into a different type.

REGRESSION MODELS:

The regression model fit for the community representative non-user group was able to explain 27% of variance only for the equation of family cohesion. The non-user family cohesion revealed a relationship between the past year total number of stressful life events and family cohesion being connected. This brings to the fore that the non-user families do face a higher amount of stressful life events yet the family cohesion remains connected. Hence, adaptation does not find a relevance in the model fit that was generated.

Based on this the study hypothesis one is accepted which states that lesser the life events in the past year better the family cohesion among families of non-users. It is substantiated that stress due to life events are universal and impinges every family. The intensity if less does not affect the cohesion of the family. Based on the above, examining the alcohol and drug dependents families for cohesion and adaptation did not predict a significant regression model fit.
When both the group of dependents were combined to represent the substance abusers specific prediction models in terms of the other two hypotheses considered for the study were forthcoming.

The second hypothesis relating to an inverse relationship between substance abuse profile and family cohesion was accepted based on tables 33 - 38. It is seen that lesser the age of the abuser, higher the years of use, being in unstable employment or unemployed with social consequences, psychiatric illness, suicidal behaviour, help seeking related inversely with disengaged family cohesion characterized by lesser commitment and little closeness indicating more of separateness among the family members.

Similarly the third hypothesis considered for the study is accepted based on the model fit specifically derived from tables 43 and 44 and substantiated with other variables in tables 45 and 46. There is a direct relationship between lower coping and rigid adaptability type in families of substance abusers. This is further fostered by factors relating to the substance abusers in terms of their lower age at initiation, higher years of substance abuse, presence of psychiatric illness, higher the number of times having been abstinent and more the number of help received related to lower adaptability leading to rigid family type.

The familial adaptation to substance abuse is figuratively summarized in figure 4. The variables considered in the figurative description are derived from prediction models obtained on the regression analysis. The non-user families were not considered in the presentation. Both alcohol and drug dependent group does have the problem to a significant extent. The arrows in terms of its directions indicate the intensity in the said area between the substance abuse groups studied.
FIGURE 4: FAMILIAL ADAPTATION TO ALCOHOL DEPENDENCE

PSOS
Middle age
Illiterate
Maritime occupation
Married
Nuclear family
Life cycle - School age
Family history+

Higher age-initiation
Higher years of use
Ulcer \ gastritis
Frequent conflict
Suspiciousness
Suicide attempt - spouse
Debts/Lying
Arrest
Job irregularity

FAMILY REACTION
Initial anger
Currently helpless
Separations

STRESS
Health
Life time total
HELP SEEKING
Ill Health

FAMILY NEEDS
Stop abuse
Role functioning
Family regrouping

ADAPTABILITY
Non assertive
Low leadership
Low negotiation

COHESION
Bonding
Coalitions
Boundaries
Disengaged

FAMILY TYPE
Extreme
Rigid

COPING
Acquiring SS
Mobilising FS
FIGURE 5: FAMILIAL ADAPTATION TO DRUG DEPENDENCE

- PSUS
  - Young age
  - Illiterate
  - Maritime occupation
  - Unmarried
  - Nuclear
  - Life cycle - Launching
  - Family history+
  - Younger age-initiation
  - Multiple drug use
  - Ill health
  - Feeling ashamed
  - Suicidal attempt
  - Suicide attempt - spouse
  - Lying/thefts
  - Drug use arrest
  - Job irregularity

- FAMILY REACTION
  - Initial Anger
  - Helplessness
  - Separations
  - Violence

- FAMILY NEEDS
  - Stop abuse
  - Specific needs
  - Problem behaviour
  - Financial needs

- STRESS
  - Health
  - Life time total

- HELP SEEKING
  - Ill Health
  - Hospital

- COHESION
  - Bonding
  - Coalitions
  - Boundaries
  - Disengaged

- ADAPTABILITY
  - Assertiveness
  - Higher discipline
  - Higher negotiation
  - Rigid

- FAMILY TYPE
  - Extreme
FAMILIAL ADAPTATION TO SUBSTANCE ABUSE - A THEORETICAL FORMULATION:

An attempt is made here to build up a theoretical formulation based on the multivariate analysis made in the earlier chapter. The basic objective of the current study was to find out the familial adaptability among the substance abusers. Families of substance abusers are part and parcel of the basic community who undergo the same lifecycle situation as others. Viewed from this perspective, we do see from the results that emerged from the current study that substance abuse families either be it alcohol or drug abusers do undergo similar life events but are having an added factor of the stressor produced due to substance abuse.

The results clearly demarcate the paradigm shift of substance use/abuse from a stress relieving phenomena to that of a long-term stressor for the family and the individual. When an additional stressor is placed on the family the families of the alcohol and drug dependents do react to the situation in a differential manner compared to the non-user families in the same community.

Though the environmental issues are conducive to the use/abuse of these drugs we do find that it does attract very young able-bodied males from the community than others. The attraction of these young males, not only makes changes in the life of the individual but also the family life cycle. It is clearly seen that families that need to be empty nest do still remain at the launching phase.

The profile of the drug user to abuser occurs within a short span and takes the family with anger and anxiety. Yet these families do perceive the need for professional help only when physical health problem that is associated with drug dependents becomes visible in terms of withdrawal symptoms and the social
consequences like thieving and violence are manifested by the drug dependents. This makes the family to avail help seeking much more frequently than that of the alcohol dependent expecting a cure and the dependent becoming normal. The other place where the family is held is that of having children and the family is not able to progress as the breadwinner gets fixed to the drug abuse at this stage.

The scenario in comparison for the alcohol dependent occurs among middle-aged married males and their children are in the pre-adolescence or adolescence phase. Alcohol problems are of a longer duration. The key members of the family undergo the crisis during the initial phases when they are much younger. The salient features here is the longstanding nature of the problem, the time allowed for assimilation of such a problem being higher in comparison to drug dependents. Forceful withholding of the family to a particular life stage predominantly occurs with families of drug abuser than the alcohol dependents.

Having these differences, looking specifically into the cohesion of substance abusers it is seen that disengagement is much higher. In terms of adapting to the situation or adaptability the families of substance abusers were more rigid. This leads to the extreme family types as described by the Circumplex Model, which forms the basic conceptualisation of the present study. Variations as understood from the present study leads to the questions - how do families of substance abusers cope with such a situation? What aids the process of resilience in the families of substance abusers? The answers to the above lie in the functioning of these families.

The family as a basic institution is one such institution that has survived centuries of change and growth. It has borne the several strains and is still hailed
as the answer to several problems. Underlying this is the significance as a system
that can provide the haven and succour to the individual at the basic level and has
several strengths. The Indian families are characterized to be a root organism
wherein every member in the family is rooted very definitely and it does
accommodate the person with pathologies or deviance. Under such
circumstances, the family goes above the level of threshold in its tolerance level,
which is a positive feature of the Indian families.

Newer drugs from natural to synthetic, changing patterns and methods of
consumption has a differential impact on the individual and invariably to the
family he belongs. Thus, the families have to face this additional burden of a
dependent family member. The rampant abuse has affected many a productive
youngster and the families. The consequences are many. Alcohol abuse limits the
development of the individual to a great extent. Drug abuse impairs the
development and the young adult is unable to move on to the other stages of life.
The banning of cultural use of sundisom among the fisher folk and the sea-related
occupation and livelihood in the area of study has shown the use of alcohol and
drugs by the people of the community.

The family responds to the person with addiction at times reasonably, at
times negatively or ambivalently but through it all, they never desert or abandon
the person. This occurs even if his functioning is not adequate and characterized
by violence, frequent conflicts and inadequate provision for the family. This
draws our attention to the different processes in the family that keep the person
within. The study results showing cohesion and adaptability in these families
point to several dynamics that go to sustain the family.
Culturally, marriage is a sacred relationship for many women. The Indian woman is socialized to love, nurture and be submissive to the husband and makes many women bear up with the inconsistencies of the dependent husband's behaviour. Further, low levels of education, lack of financial independence and social stigma associated with a broken marriage and the ultimate hope of change in the spouse go a long way in keeping the family intact even if few separations occur to deal with unbearable crisis. The tolerance of male deviance and the cultural strictures of a virtuous woman's role prevent them from responding by drinking or deviant behaviour as reported in Western literature.

Cultural values of consideration, tolerance, care and duty are also other factors facilitating adaptation of families to the problem of substance abuse in the face of myriad problems. The spouse maintains the family by keeping the children together with her and builds bonds with the dependent father moving in and out of the system in keeping with his states of drinking. The stresses faced by these families are higher as economic damages impinge on them. The woman, who dons the mantle of functional leadership, emerges as the breadwinner of the family when she is neither trained nor experienced in working in the modern economy. Working in an unorganised sector to overcome such a situation they are further marginalized. The supportive function provided by the joint families is seen to be lacking in the area as a majority of the families with substance abusers are found in nuclear families. The few joint families of the drug dependents are seen to provide this support more clearly of increasing the economic stability by the other members of the family. This is especially by the women folk of the family like the spouse or the mother of the dependent member.
The normative stress being high and coupled with the chronic stress of alcohol dependence still reveals better cohesion among these families. This shows that these families have the ability to endure hardships. The jointedness or the functioning of the family as an integrated unit in spite of the problem in the family member could be due to various factors as outlined below.

Hailing from a fishing community background they are known to be daring people. The women prepare and send their husbands to sea each time fervently praying that he returns safely often reminded about the dangers at sea and the prospect of losing him. The culture of using sundisoru, or alcohol to ease the muscle strain and rigors of fishing increases their tolerance to abuse. The high level of family history of abuse of substances shows that the spouses may also have been exposed to drinking in their families of origin.

The fishing community thus provides the context in which the behaviour is shaped and conducted. The opportunity structure, the available role models, the reinforcement contingencies that further shape behaviours, the social norms perceived, the beliefs, attitudes and values and the self-perception of an individual are for the most part influenced by his or her social environment and in turn reflect his or her behaviour. Based on the community context the family unit presents the critical lifestyle determinate for individual family members. It is well known that the establishment of regular routine habits and life patterns largely occurs within the precincts of the family, while conversely, the absence of them also finds its origin within the family.

The families of drug dependents in having half the population with single status and the other half married showed a different picture. The severity of
addiction reduced marriage prospects for many of them. They lived with their families of origin. For the others who were married most of them hailed from nuclear type of families. So in having young children these families had to make a lot of adjustments very early in marriage and forced the families to be flexible to change. However, as drug abuse was often present early in marriage, the cohesive bonds could never be developed enough. Further, in families of origin with the families having to cater to the needs of other growing members these families probably had to be more flexible in adapting even if cohesion was less.

The tolerance in the families of a non-functioning member relates to the familial duty of parents in the Indian cultural ethos to care for their children. Thus mothers feel a sense of duty towards their grown up sons even when they cannot care for themselves. Families also have a fatalistic passive orientation to control as ‘karma’, which is acceptance of one’s circumstances as a result of the conduct of one’s life in the previous birth. This sometimes makes situations acceptable and does not allow people to break away from a problem. ‘Belief in destiny or fate’ that ‘what is written for them/or willed by God, will happen’, also influences. Further, strong belief in horoscope and astrology, timing in one’s life, good and bad periods in one’s life determines acceptance of certain unpleasant events. Besides family traditions, values and identity, cultural beliefs influence the way families perceive problem situations and make it manageable. In addition, the belief that God will take care and the support of family and friends ease the burdens of the families. All these point towards external locus of control.

The family is not without it’s negative emotions of violence, anger, conflicts, ambivalence and suicide attempts but the ultimate hope surfaces in
many families that the family member would give up his habit and integrate with the family fully. Thus the spouse alters, reduces her expectations from her husband and seeks ways of salvaging the family and its pride. She covers up for the husband or family member, brother or son. The families also cope by trying treatment, going to temples, prayer groups, converting to a different religion building up their hardiness and endurance. In the face of such family resilience we are seeking to understand the familial adaptation to substance abuse. We find the answer is not so simple to elucidate.

Families are defined by complexities and they are progressive and dynamic in function. To place a family in a specific time perspective and to understand it is a simple attempt to bring some order into a very heterogeneous entity influenced by several systems of a society. To understand families in a longitudinal perspective calls for much more understanding of the factors involved. That families are naturally in a life span perspective has to be acknowledged and is unique in its responses to the transitions it has to face within it and dependent on the age and stage of its different members. The family withstands this basic onslaught by not breaking or moving out of the boundaries of the family. In spite of the added stressor on the family, the person is maintained in the family. The families do stretch themselves to maintain and contain the person with substance abuse within the family.

In this process though we find a pathological cohesion of being disengaged or getting adapted to the situation by being rigid, pushing the families towards the extreme range of family ties makes one realize the patho-elastic nature of the family in the Indian setting. This in comparison to a western family could have
led to a patho-plastic effect of breaking away from the basic institution of the family or piercing out of the family boundaries either by the substance abusers or the other members of the family. In spite of the extreme family type identified in the families, none of these families have let the constant stressor-producing individual out of the family boundary.

The adaptation of the Indian family is not towards one single issue of substance abuse. They undergo a large amount of stress as seen through the number of life events that occurred over the lifetime and the last year. The adaptability dimension is associated with the years of use, age at initiation, psychiatric illness, help received, number of times abstinent and family coping described earlier. This model fit was able to describe fifty percent of the variance.

Other aspects not covered in the current study could also be contributory to the problem. All these factors probably influence their adaptation that is not so flexible and characterized by rigidity in trying to maintain the family functioning with a frequently absent member occupationally and psychologically when under the influences of substances.

The contribution of such a member over many years of heavy use leads to a traumatic outcome that disables at a relatively young age, resulting in the loss of years of life with disability. Such an outcome on the individual in turn affects the family with severe drain on social, psychological and economical resources. The impact of this leaves the family with loss of quality associated years of family functioning. These additive effects lead to an extreme family type among substance abusers characterized by the term 'Impacted Adaptability'.