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INTRODUCTION

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RELEVANCE OF THE STUDY
In a world catapulted into change by the various advancements in science and technology, the whole world has become a global village. The boom in information technology has opened new vistas in communication. This information explosion into the homes of ordinary people has caught them unawares. Fed in with new ideas, concepts, values and ways of living it has thrown out of gear the slow, steady pace of our society. The cities are in a state of flux with newer lifestyles emerging.

The family as a basic living, evolving social institution is a significant part of the global transformations. As the world's oldest form of expression of human relationship, families have survived thousands of years adapting constantly to changing socio-economic conditions and progress of humanity. It has not escaped the impact of the complex problems brought by the advancement of civilisation.

Structure and functions of the family and lifestyles have undergone changes. With women seeking education and both spouses employed in many instances, the traditional roles of husband and wife have altered. These transformations place further difficulties on nuclear families having to cope with child rearing and other aspects of family living. Role strains occur and family problems are on the rise. The pressures of everyday living are increasing and man eagerly awaits an outlet. Social interactions within families are decreasing with the entry of television and other modern forms of entertainment. The lure of different lifestyles is challenging traditional family values and creating discord. With all these changes the disadvantaged sections in society are at a further loss when it comes to facing life. Disparities in education, occupation, income and styles of living are widening, bringing to the fore frustrations, dissatisfactions and hostility. Lack of entertainment and constructive leisure affects their reactions to the problems of life.
Some individuals are equipped with coping skills to deal with these various vicissitudes of life, for others the burdens are unbearable. Social supports that individuals possess and their ability to use them go a long way in dealing with life's circumstances. For many alcohol still remains the time tested tension reliever, while another group turns to more potent substances in the form of drugs to seek solace.

While dependency remains an individual habit it is of less concern for the society. However, the very nature of using these substances has undergone drastic changes that simplistic reasons and factors are no longer valid. It has become a complex problem with multiple causative factors and effects. The wealth of literature that is available proves it.

Substance abuse has transcended from an individual to a public health and global problem. The global ramifications are witnessed in the influence drug money has on the economy of many countries, governments, policies, and businesses. The links between drug trafficking and terrorism has led to the emergence of 'narco-terrorism'. In many places drug money is used to fund arms buying. The narcotics organisations are well armed and trained. They have eliminated many rivals and opposition through assassination and murder. International bodies like the United Nations and Narcotics Control Bureaus are committed to curtailing the ramifications on a global level. Within countries, it is the responsibility of governments to take care of the problem. The dependent person is again the centre of focus.

While the problem of alcohol and drug abuse might seem to have moved out to the macro-level, it is still very much a part of the micro-level of society as it affects the family and immediate society drastically. Any attempt to change the situation therefore has to be multi-pronged and has to start at the family level.
In this context, Social Work as a helping profession finds relevance. It seeks to enable individuals to live a rich and full life based on scientific knowledge and skills through its methods of casework, group work and community organisation (Hamilton, 1953). Further, it has been able to adapt to the various needs and social problems of modern society and has found application in dealing with special populations such as street children, terminally ill patients, disaster populations, refugee settlements and substance abusers.

The field of substance abuse is a specialized area of intervention. Working with alcohol and drug dependents requires new methods and approaches. These clients are plagued by personality problems, social maladjustment or have had disruptive home influences and consequences. Treatment cannot be complete until these earlier problems are worked through. Social workers provide these services.

Support systems are very crucial in the recovery of alcoholics so families are indispensable. Wives and children have been studied extensively for their roles in perpetuating abuse and the impact of alcohol on them (Jackson, 1954, 1958; Orford, 1976). Thus, the family adopts a certain style of functioning. This enables it to carry on with the problem, whether healthy or unhealthy. Intervention with the family's response to the dependent person goes a long way in facilitating the recovery from alcohol or drug abuse.

While a few dependent persons seek treatment the majority live in the community untreated. The person dependent on substances denies his problem and often resists treatment as help seeking labels the problem. They seek help for individual medical problems whereas many others have financial, social and legal consequences.
The families are left with the individuals and cope with them. Over time, they develop a style of adapting which may be healthy or unhealthy. It becomes imperative to recognise the other means of helping them cope, the positive aspects are essential thus reducing their guilt. In this context, families are still the primary resources, which are strong and lend themselves to working. The families have strengths, which need to be recognised to work with, rather than the pathologies within (Giblin, 1996).

Earlier emphasis on the 'damage-deficit' model focused on events that happen or fail to happen in clients' lives and conveyed a sense of victim-hood to clients. Today it has moved to a 'challenge model' highlighting coping strategies, empowerment and living into the future (Wolin and Wolin, 1993). Institutionalised treatment of individuals and problems need to be supplemented with family and community based approaches. In the field of substance abuse also, this is the emerging trend.

SOCIAL CONTEXT OF SUBSTANCE ABUSE

The seriousness of the problem of substance abuse is evident from the importance given to it internationally in the formation of the Expert Committee on Habit Forming Drugs in 1948 i.e. ever since the inception of the World Health Organisation (WHO, 1993). In 1968, the Committee was renamed as the Expert Committee on Drug Dependence. Similarly a global picture of the status of alcohol as a factor of world health marks the beginning of the Global Alcohol Initiative (WHO, 1999). In the 1960's, the so-called 'explosion' of drug use took place and spread to many countries. The use of illicit drugs such as heroin and cocaine had
increased and there had been increases in the harmful use of licit drugs and alcohol especially in developing countries. Tracing the patterns of use it is seen that alcohol has shown a decline in developed countries and increased dramatically in developing countries. Synthetic opioids, benzodiazepines and anxiolytics have appeared in the market. Developed and developing countries reveal an enormous growth in the world supply of illicit drugs. The rise in illicit drugs coupled with changes in preferred routes of administration of cocaine and opioids, has severe public health implications.

The shift in the markets of licit and illicit drugs meant that many countries that originally only produced illicit drugs also consumed them and those that were only consumers of licit psychoactive medicinal drugs became producers. There were strong reactions in many countries and many industrialized countries enforced stricter control measures. This prompted traffickers to locate laboratories for production of both cocaine and heroin in the developing countries that provided the raw material. The availability of refined drugs of high purity and at low prices has expanded the markets for these drugs. This is especially so in these and neighbouring countries. Given this scenario, campaigns against drugs increased in the 1980’s in many countries.

As a result more resources were directed to law enforcement and treatment. The high numbers of drug-related arrests made prisons take precedence over treatment (WHO, 1993). The WHO has estimated the number of drug addicts in the world to be over five crores (Paul, 1996). With this magnitude one needs to understand the plight of five crore families who not only absorb but become problematic themselves.
Approximately 54% of distilled spirits worldwide are so called traditional or local products (Impact Databank, 1995). Some previously local products have become global commodities. Local products like arrack in India figure prominently in formal national economies. Thus, the line between this category and global commodities becomes less clear. Some of these local products with fifty percent alcohol strength pose health hazards through their presence in informal economies (WHO, 1999).

A 'combined approach' to viewing alcohol and drug problems is emerging worldwide. Public health approach to treatment has recognized the need to be more aware of both problems and the need for intervention of more than one drug related problem. This has prompted a closer co-ordination between mechanisms and agencies for the control of illicit and licit drugs.

Given the current substance abuse scenario, the socio-cultural factors are being emphasized in contrast to individual and purely psychological factors. Tourism not only brought into contact other customs and behaviour, but also enabled people to experiment with psychoactive drugs and local illicit liquors that might not be available at home.

Social scientists have interpreted drug abuse as partly a response to 'alienation'. People not rewarded in the mainstream of society opt out and seek alternative gratification from drugs. More generally, theories suggest that, even if drug use is not a response to educational failure or economic deprivation, it may be due to other social pressures and changes, not confined to the poor.

In societies or sections of society where the social conditions are disrupted by poverty, migration or rapid socio-economic change, the problems of drugs flourish.
The punitive response to illegal substance use makes a user become even more isolated and deviant. Apart from the user becoming deviant or isolated, the spouses and other family members also face problems avoiding the shame and guilt of facing the society (Ranganathan, 1983).

The social context of substance abuse indicates that the above changes make the present and future substance use situation more difficult to control. In the past, most societies have had only one or a few dominant psychoactive drugs or liquors that caused problems. Their long usage enabled societies to develop informal norms of acceptable and non-acceptable use that served to partly control harmful use. The absence of these informal buffering mechanisms for substances that are new in a society makes formal control efforts by national governments more difficult and important than before.

CONSEQUENCES OF SUBSTANCE ABUSE

The problems due to substance abuse are innumerable in the physical, mental and social domains. This has led to a pathological situation of not viewing the addicted individual as part of the family. The consequences of the families of substance abusers have so far been underestimated and underreported. The strengths as well as the problems faced by families are gaining importance currently. Patterns of substance use vary greatly from one culture to another and between groups in a culture. The problems vary dramatically for the same drug. The social consequences of drug use are determined by environmental and the legal status of the drug.

An illegal drug affects the pattern and mode of administration with illegality tending to push a drug into more covert concentrated forms and its use into more
health threatening modes of administration. Criminal law also regulates use of alcohol as in drunken driving. The social problems arising out of drug use depends on the extent to which the behaviour is tolerated or sanctioned by others, whether family members, colleagues, friends or strangers. This tolerance is strongly affected by cultural norms and public's perception of the drug use and its consequences.

The family of the drug user may be adversely affected by the time and money spent on drug use. At a broader level, problems related to alcohol and drug use affect productivity - for example absenteeism, occupational morbidity, inefficiency on the job and safety hazards. Drug use and associated problems affect health care costs, welfare costs and costs associated with the criminal justice system (WHO, 1993).

DRUG SCENE IN ASIA AND INDIA

In understanding the drug scenario in the world, the importance of the Asian region in being the location of the 'Golden Crescent' (Pakistan, Afghanistan and Iran) and the 'Golden Triangle' comprising of (Burma, Thailand and Laos) cannot be overlooked. India is conveniently sandwiched between the two. Afghanistan is the world's second largest producer of illicit opium after Myanmar (Burma).

The drug abuse problem was not so serious in the 1970's. It was only after the dethronement of the Shah of Iran followed by the Iran - Iraq War and the Afghan invasion by Russian forces that the main transit of the 'Golden Crescent' was shaken. The drug traffickers then looked towards India as a transit zone for entry of drugs to the US and other European destinations. Delhi and Bombay (currently Mumbai) emerged as major 'Gateway Ports' for illicit export of drugs especially heroin. India
was primarily a major transit country and soon earned the distinction as a user country due to the spill over effect.

India also cultivates opium under license. However, the total production of opium is not surrendered and there is leakage from the growing areas, besides there is organized illicit cultivation of opium poppy in Uttar Pradesh, Arunachal Pradesh, Manipur and Mizoram (Kumar, 1996). Ganja is cultivated illicitly in several parts of India, in Jammu and Kashmir, Manipur, Kerala, Tamilnadu and Andhra Pradesh. The International Bureau of Narcotics reported that the narcotic trade in India involves around Rs.5000 crores per annum. About one million are opium users and several million take cannabis (Ray and Sharma, 1994).

**DRUG ABUSE SCENARIO IN CHENNAI CITY**

The present study has been conducted in Chennai (the erstwhile Madras) city of Tamilnadu. In Tamilnadu the use of ganja (cannabis) had been in vogue for centuries. Sadhus (sages) used ganja and there were ganja mutts (akin to clubs) where sadhus and sanyasis (saints) assembled and smoked ganja. In the 1960's and 1970's as western music became popular, cannabis became the 'in-thing' among college going youth (Government of India (GOI), 1977). Other drugs such as dextroamphetamine (dexamphetamine) and methaqualone (mandrax) were also popular drugs of the decade and were banned in 1980's.

Cannabis dependents were also from the lower socio-economic class and comprised of rickshaw pullers, auto drivers, casual labourers and others engaged in skilled work. Fishermen and painters used cannabis more than others. Substance abusers being from the lower socio-economic class do spend a large amount of their financial resources earned, towards the substance procurement. This leaves the
family in the lurch including its inability to meet two square meals a day. Certain pockets of Chennai were popular for cannabis such as Clive Battery, Royapuram, Kasimedu, Vepery and St.Thomas Mount.

The year 1983 was a significant landmark in the history of drug abuse in Tamilnadu. The Sri Lankan refugees following the ethnic crisis landed in Madras from Jaffna some of them sold drugs and brown sugar became available. In 1985 this habit soon spread to the low-income groups and slum dwellers in the age group, 15 - 25 years.

The patterns of use were predominantly chasing of brown sugar in 1988. Since 1988, escalating costs of brown sugar increased the search for substitutes driving many to poly drug use. Prescription drugs like nitrazepam, diazepam, and dextropropoxyphene were increasingly abused. At this time, some medical practitioners used buprenorphine to treat the agonizing heroin withdrawal symptoms of heroin, unaware of its addiction potential. Soon drug users began to use buprenorphine at times of street heroin scarcity and raids.

The assassination of Rajiv Gandhi established Sri Lankan terrorists' involvement and led to a scarcity and shortage of heroin. This shortage prompted a number of brown sugar users to shift to the easily available synthetic opiate preparation, buprenorphine through fixing.

The former heroin chasers were now using buprenorphine and injecting it regularly. Some shifted back to brown sugar when it became available in the illicit market, some used both. Soon buprenorphine was subjected to stricter drug control in Madras and thus became available and was cheap in the illicit market. Many drug users soon turned to buprenorphine.
In Chennai with the escalating availability and use of buprenorphine, opiate injecting steadily increased since 1991. Injecting drug users are mostly seen in certain geographic locations in the city such as Royapuram and Vepery. Many new users are initiated to opiates by injecting (Kumar et al., 1998). The total numbers of drug abusers in Chennai are reported to be 25,000 (Kumar et al., 1999). The national picture is also alarming. The Ministry of Welfare, GOI has projected the number of drug abusers in the country to be 2.25 million (GOI, 1992). This being the scenario of drug abuse it is relevant not only to understand the policies governing alcohol and drug abuse but also the magnitude of the problem faced by the family.

ALCOHOL POLICY

The consumption of alcoholic beverages has not had a general and respectable vogue in India. Consumption of small quantity of liquor was not opposed, but medical literature has mentioned alcohol of inferior quality or in excess could act as a poison. The learned men, religion and social tradition had condemned the consumption of alcoholic beverages and encouraged abstinence. With the advent of the British in India, drinking became a status in society. The states in India became aware of the value of liquor, as a source of revenue.

Unlike western industrialized countries reliable data on alcohol production, marketing and varied alcohol related problems are not readily available in India despite the growing malaise of alcoholism. Revenue from sale of beverage alcohol is now a whopping 17,000 crores from different states. The advent of delicensing and economic liberalization has brought several multinational liquor giants into India and introduced a competitive atmosphere in the liquor trade (Ahluwalia, 1996). Currently, there is a need for a comprehensive national policy.
Regionally Tamilnadu has had long periods of prohibition between 1933 and 1981. In 1981, prohibition was once again revoked. The policy towards alcohol was thus in the hands of the individual state governments (Ranganathan, 1985). Since 1983-84, the state government implemented a modified prohibition law under which drinking of toddy, arrack or liquor was permitted subject to certain conditions. The Prohibition Enforcement Wing in the state enforces prohibition under the Tamilnadu Prohibition Act and Rules of 1937. Despite these measures illicit liquor is very freely available.

DRUG POLICY

The growing dimensions of the substance abuse problem brought into focus the inadequacy of the existing laws. The legislations to deal with drugs enacted by the GOI till 1985 were The Opium Act, 1858, The Dangerous Drug Act, 1930, The Drug and Cosmetics Act, 1940, The Medical and Toilet Preparation Act, 1953, The Customs Act, 1962 (Anthony et al., 1994). Most of these acts related to the manufacture or cultivation of the substances. The purpose of these enactments was to control trade and increase revenue. Drug abuse or trafficking was not the thrust of the legislation.

The incipient rise in the abuse of drugs and other factors were the driving forces that necessitated the preparation of a legal measure of control. The Narcotic Drugs and Psychotropical Substances Act (NDPS Act) GOI, 1985) was framed due to the inadequacy of the existing legislation in the face of changing patterns of consumption, production and trafficking. The act though very stringent had many loopholes in its implementation. Increase in trafficking and the guilty going scot-free
resulted in amendments in 1988 based on the recommendation of the cabinet committee constituted for combating drug abuse.

To make this legal aspect more effective the Prevention of Illicit Trafficking in the Narcotic Drugs and Psychotropic Substances Act (PIT NDPS Act) GOI, 1988) was formulated. In the amended Act, death penalty for certain offences after previous conviction has been included. It has provisions for constitution of special courts for the purpose of providing speedy trial of offences. It provides immunity from prosecution to addicts volunteering for treatment. There is a whole chapter on property derived from and used in illicit traffic.

The Government of India has constituted the Narcotic Control Bureau with its headquarters in Delhi with effect from 1986 with a Director General and has zonal offices in Delhi, Mumbai, Calcutta, Chennai, Jodhpur and Varanasi. This bureau exercises the powers and functions of the central government under the Act and co-ordinates actions between various offices, ministries, state governments and authorities under the drug-related acts.

At the state level, the Narcotic Intelligence Bureau of the police implements the NDPS Act and the PIT NDPS Act. The Office of the Joint Commissioner Excise is a regulatory body issuing licenses for bonafide, medical and commercial use of drugs. In spite of the deterrent strictures the drug trade is still booming in India with very few convictions and is a cause for concern.

The National Mental Health Programme for India (DGHS, 1982) has documented the disturbing rise of alcohol and drug abuse in the country. It further states the need to ensure community involvement in preventive efforts directed at psychosocial problems like alcohol and drug abuse. Policy oriented research provides
the scientific information for the whole area of substance abuse (Saxena and Edwards, 1998) though this kind of research is scarce in any country and almost absent in India (Saxena, 2000).

TREATMENT SCENARIO

On the demand reduction side the Ministry of Welfare in different parts of the country has established several specialized intervention services in the past decade. They include detoxification facilities, counselling centres and aftercare facilities. Over the years most of these centres provide care for predominantly alcohol-related problems (Jiloha, 1991; Murthy, 1994; Isaac, 1992).

Chennai also responded by setting up a forty-bed de-addiction centre for the detoxification and psychosocial management of alcohol and drug dependents in the Government Institute of Mental Health. In the voluntary sector there are few agencies focusing on holistic management like the T.T. Ranganathan Clinical Research Foundation which has medical and psychosocial management such as individual counselling, group therapy, family counselling, self-help groups, networking with industries, relapse prevention and aftercare programmes. Other centres like ‘Arogyam’ and ‘Punarjeevan’ have counselling programmes. St.Paul’s Deaddiction Centre has detoxification services for drug addicts, ‘Asha Nivas’ runs a prevention centre for drug dependents. ‘Sahai Trust’ is a church based rehabilitation centre by The Archdiocese of Madras. Based on the therapeutic community philosophy the centre is managed by ex-addicts. The Sahai Trust runs two outreach centres in the community at Periamet and Perambur to reach out to alcohol and drug dependents in their drug milieu. Many of the centres are paying facilities, given the
nature of addiction and costs of maintenance. Stella Maris College has an outreach centre called 'Sangamam' in Kasimedu, motivating addicts in the community to seek treatment and follow-up after treatment by counselling them.

Given the magnitude and the emergence of the substance abuse problem, the various legal, administrative controls clearly indicate that the problem is not contained. The number of substance abusers in Chennai has been on the increase. Further, the treatment scenario is inadequate in comparison to the prevalence of the problem. The treatment revolves around the individual with the problem rather than the family in which s/he lives. Families need to be involved as most often alcohol and drug dependents do live within the family. In spite of the many changes in society that have altered their roles and functions, families continue as basic units in society. They provide the natural framework for the emotional and material support essential to the growth and well being of their members.

Families are undergoing several transformations and problems and addiction is one of them. Family support facilitates better recovery for the individual. If educated, motivated and involved, the family of the addict can guide and support the addict through the process of acceptance of the fact of addiction, detoxification, treatment, relapse and rehabilitation, in an effective manner. The same process can also help the family members to obtain relief and alleviate the damage done to them and their sense of self-worth. It may well help an ailing, dysfunctional system to acquire a rejuvenation and functionality that will do wonders for the system as a whole, and consequently, to the individual members, as well.

Around the globe many governments are retreating from a leading role in providing social services and are returning that response to families. This movement
finds expression at the highest policy level as well as the lowest level of field practice. Social workers, teachers, health care workers and others routinely include the family among the resources available to solve the problems with which they deal. The growing trend is to entrust families with the responsibility for meeting multifarious human needs. For diverse reasons, families are not always ready or able to take on these responsibilities nor are they significantly empowered to be effective.

STRESS

Contemporary family life as described above is associated with a lot of stress. Urbanization, geographic movement, class mobility brings together marital partners from different backgrounds. Inequalities in their values and aspirations become a stressor in itself. Further, in the life span role transition takes place and brings stress into the lives of the persons – marriage, child rearing and death of spouse are scheduled events. Similarly, unscheduled events such as injury, illness, job disruption, premature death, and ruptured friendship are also stressful (Pearlin and Lieberman, 1981). People have different ways of relieving stress and alcohol is one of the stress relievers.

Alcohol and stress are related. It often serves as a stress reliever for the individual by its sedative and central nervous system depressing effect. Soon an excitatory condition emerges clinically as the dependent effect wears off. This latter effect of alcohol is a cause of further stress requiring additional sedation and other methods of coping (Peyser, 1982). Drug abuse too has properties of coping with stresses. Soon it also becomes a stress as the individual gets immersed in the problem and has difficulty in maintaining the habit. His behaviour creates problems
for the family too. Thus, family stress is a reality and the family has to find ways of dealing or coping with it.

In the earliest family stress researches, Hill (1949,1958) described the classical ABCX model wherein A (the event and related hardships) interacting with B (the family’s crisis meeting resources) interacting with C (the definition the family makes of the event) produce, X (the crisis) the stressor.

Doherty and Campbell (1988) who pioneered the bio-psycho-social theory of stress report that the human body continually strives to attain a homeostasis in function. Life events that upset the body’s balanced state call for a readjustment. Too many changes in life, tax the body’s ability to readjust. The result is stress, the body’s physical and psychological reaction to a multitude of demands for readjustment. The common life events occur at all stages of the life cycle. Thus, the way a person or a family will cope with stress depends on specific family resources and the type of family system. Holmes and Rahe (1978) researched much on the relationship between life changes and signs of emotional and physical stress in individuals.

Families it is proposed construct and share meanings about specific stressful situations, their identity as a family and their view of the world. For families with a chronically ill member, they define the situation and attribute meaning to the illness event. This is followed by change at the other two levels. Family identity changes allowing the illness and hardships to have a place in family life and this evokes a change in the family world view or how family members see themselves in relation to the rest of the world.

When discussing about stress, the aspect of coping or adaptation is perhaps inevitable. Many studies have been carried out to understand how families adapt to
various types of stressful experience. An attempt has been made to understand those factors associated with the adaptation to the chronic stress of disabling conditions. Cognitive factors have emerged as important. These cognitive factors go beyond the definition the family gives to the stressor (the onset of disability) as families search for meanings in a life that in many ways has been shattered by added demands, multiple losses, change in routines, roles and expectations. These meanings get reconstructed as the family faces the chronic illness. The different levels of family meanings influence the coping and shape the processes and outcomes of family adaptation to chronic stress.

COPING

The family's perception of the original stressor events was expanded to include the family's perception of other stressors and strains, plus their perceptions of family resources. This latter perception is what Lazarus (1966) called secondary appraisal, that is appraisal of capabilities or the ability to manage the stressors and strains. Mc Cubbin and Patterson (1982, 1983a, b) termed the same as the Double ABCX Model.

Another way that meanings were included in the Double ABCX Model was in terms of 'coping', which was defined to include both cognitive and behavioural strategies. In this model, a coping strategy that functioned to alter meanings to make a situation manageable was emphasized. In addition, a more generalized meaning construct called a sense of coherence was added (Antonovsky, 1979, 1987). This was defined as the family's ability to balance control and trust - that is, knowing when to take charge and when to trust in or believe in the authority and/or power of others.
To emphasize adaptation as the central outcome of the other process, the Double ABCX Model is now called 'The Family Adjustment and Adaptation Response (FAAR) Model' (Patterson, 1988, 1989), to emphasize potentially positive outcomes (Patterson and Garwick, 1994). This focus on adaptation is consistent with the many studies now focusing on family and individual resilience in the face of stressors and risk factors.

The family coping patterns are not created in a single instant but progressively modified over time. The coping emerges out of the way the family responds to stress collectively. It involves the maintenance of satisfactory internal conditions for communication and family organisation, self-esteem, family bonds and social supports. The social support that a person has is known to have an influence on the impact of the stressor. Friends, family members, relatives and community resources exist in a network in society. These supports have a buffering or mediating impact on the magnitude of the stressor. Their availability and accessibility influence a great deal and help to meet the functional needs in a routine or crisis situation.

When we consider substance abuse we realize that the family is under stress and can be considered as family stress. The family especially the spouses and other family members respond in several ways. They build meaning into the situation, understand it and device ways of coping based on previous experience and resources available. However at times when stresses are continuous it has also been found that they lack a coherent plan. The uncertainty, unpredictability of the dependent person’s behaviour, the failed promises, varied hardship influence the adaptation the family will make. The adaptation of the family emerges as strength in consonance with its cohesion and communication patterns.
The identity that a family builds also helps it to deal with stress. However, family identities are not easy to articulate. The role of family rituals in maintaining a family's sense of itself as a collective whole, in establishing shared rules, attitudes and ways of relating, as well as in maintaining continuity and stability in family functioning over time has been emphasised (Wolin and Bennett, 1984; Bennett et al., 1988; Imber-Black et al., 1988). Families vary in their commitment to rituals, and there is some evidence that under-ritualised families may experience more dysfunction (Imber-Black et al., 1988). In studies of factors associated with alcoholism, high levels of commitment to family rituals were and are protective factors in reducing the intergenerational transmission of alcoholism (Wolin et al., 1980; Bennett et al., 1987; Steinglass et al., 1987).

In the Indian scenario, coping strategies are influenced by their belief system of 'mastery' verses 'fatalism'. Families who believe that substance abuse has to be accepted as God's will, may cope differently from families who believe diseases have to be overcome through medical or non-medical intervention. When medical interventions do not work, such families get frustrated and adopt less constructive ways of dealing with the situation. On the other hand, a fatalistic viewpoint may result in passivity among members (Bharat, 1995). Thus, all the aspects of stress speak of change in family adaptation by dealing with the stress and coping.

FAMILIAL ADAPTATION

The issue of adaptation is how a system can change while at the same time preserving its integrity and organisational coherence. Ackerman (1958) notes that 'effective' adaptation requires . . . a favourable balance between the need to protect
sameness and continuity and the need to accommodate to change. It requires preservation of the old combined with the receptivity to the new... adaptation is understood as involving a dialectical tension between tendencies to change and tendencies to preserve sameness.

The central thesis of an organismic developmental approach is that development involves progressive adaptation and consists of a synthetic process that 'interweaves' these two 'opposite tendencies'. The goal is to achieve a synthesis of the two tendencies so that new learning can take place that will be 'in harmony with' what's come before. When these two tendencies are no longer in opposition, but integrated, a system results that is at the same time flexible i.e. able to vary with changing conditions, and stable i.e. able to preserve its identity, its internal coherence, and its continuity over time.

Further, these two dimensions are related in the sense that 'stability of behaviour requires flexibility of response in order to preserve the functional equilibrium' of a system in the face of changing internal or external conditions i.e. family trying to regain its integrity and carry out its functions (eg. spouses mutually supporting one another, parents nurturing and socializing their children), they must do this while responding to external disruptions (eg. changing economic conditions, change in location) and while responding to external changes (eg. the birth, death, illness, divorce of its members).

The issue of adaptation is linked to structure or organization. Piaget (1966) states, that it is impossible to dissociate organization from adaptation. An organized system is open to the environment, and its functioning entails exchanges with the external world, the stability of which defines the adapted character of the system.
Werner's (1957) theory says that the more differentiated and integrated structures are the more adaptable i.e. they are more flexible and more stable than those that are less differentiated and integrated. The less differentiated and integrated structures tend either to be rigid or labile, or to oscillate between these two states. Werner's contribution emphasized organisation and adaptation. Werner found that underorganised systems are characterized by lability and rigidity and the more organized systems by flexibility and stability. Specifically, the system with greater adaptability (flexibility and stability) is the one that is more differentiated and hierarchically integrated.

Minuchin (1974) has also stressed the connection between organisation and adaptation. He has described how enmeshed and disengaged family structures lack flexibility and how such stressors interfere with the family's ability to develop alternative patterns of interacting when it is called for.

The Circumplex Model of marital and family systems developed by Olson et al., (1979) bridges the gap that exists between research, theory and practice. Based on the systems theory, this represented one of the most widely used and highly debated theories and models of family functioning. The original 'Circumplex Model of Family Adaptability' consisting of major dimensions of cohesion, flexibility and adaptation was an indicator of family functioning. Olson revised this model to have two major dimensions of cohesion and adaptability. Cohesion referred to the togetherness in the family and adaptability to the ability of the families to change in the face of stress. Communication is the third facilitating dimension that helps families to work out problems. The different aspects of cohesion and adaptability define the optimal and dysfunctional levels of functioning of the families.
The essence of family adaptability is to balance stability and change. Families need a basic foundation that gives them stability, but they also need to be open to change when necessary. Change is particularly important when families are under stress and need to adapt in a crisis. The relationships that the family maintains through the different stages of life and its stresses make it evolves into a classification of balanced, mid-range or extreme families.

As the stress subsides, the family system usually returns to its customary type. Families change the kind of system they have as they develop across the family life cycle illustrating dynamic balance. The concept of balance involves having both autonomy and intimacy and the ability to move back and forth between the two. Establishing a dynamic balance between the two requires shifting back and forth on a weekly, daily or even hourly basis. Building on the concept of balance, there is a curvilinear relationship between both cohesion adaptability and family functioning. This means that families that are either very low or very high on these dimensions tend to be more dysfunctional. The Circumplex Model applies to the families of alcohol and drug dependents too. Yet few studies exist on the adaptation of families of substance abusers in relation to the family stress, coping and social support highlighting the need and scope for further intervention research. Desai (1994) stressed that the social worker needs to identify family dysfunctional dynamics and work towards the following:

- Structuring the family's adaptability pattern or making it flexible as the need be
- Bringing the family cohesion to the levels of separated and connected
- Developing positive communication patterns
- Facilitating role performance
- Developing democratic decision-making patterns.
SOCIAL WORK AND SUBSTANCE ABUSE

Many disciplines work with families, as it is an essential and basic unit of society. Social Work as a helping profession predominantly deals with families. As observed earlier, human beings are conceived as evolving and adapting through transactions with all elements of their environments. In these adaptive processes the human being and the environment reciprocally shape each other. People mould their environments in many ways and in turn, must then adapt to the changes they create (Germain, 1973).

Families have a life cycle of their own. They also move through identifiable stages of development, status changes, and crisis events, such as unemployment, or illness, posing tasks for collectivity that may not always mesh with the transitional tasks of individual members (O'Connell, 1972).

Increasingly, society has posed complex adaptive tasks to human beings at all stages of the life cycle (Gitterman and Germain, 1979). The structure and functions of familial, organisational, and other environmental systems have undergone dramatic change. The family's capacity for fulfilling its integrative functions has been taxed by its members' divergent opportunities, needs, responsibilities and interests. At the same time, institutions are experiencing serious problems in managing their intended service functions. These dramatic changes and disjunctions between adaptive demands and the resources available for meeting the demands generate stress. People's styles of coping emerge from their perceptions of environmental demands and resources and of their own response capabilities.

In this context Social Work's distinctive functions and tasks arise from its social purpose: to strengthen coping patterns of people and to improve environments
so that a better match can be attained between people's adaptive needs and potential and the qualities of their impinging environments (Gordon, 1969; Schwartz, 1971b). Professional action is directed toward helping people and their environments overcome obstacles that inhibit the development of adaptive capacities (Gitterman and Germain, 1979). This concept of Social Work practice is consistent with the ecological models that have been developing over the past few years (Meyer, 1970; Pincus and Minahan, 1973; Germain, 1973; Baer and Federico, 1978; Hartman and Laird, 1983). Based on these a holistic scheme of family assessment on its dimensions of adaptability, cohesion, communication, role performance, decision making and success in carrying out individual members' developmental tasks is needed to identify areas of intervention (Desai, 1994).

The legacy of the isolated, problem saturated family has not served well. The notions about family must also be changed in a more affirmative direction. The legacy of family pathology has geared treatment to more sophisticated analyses of failure. It has not prepared Social Workers to recognise, celebrate, and support family strengths. It is time to assert a renewed focus on family strengths and empowerment in order to encourage optimism about human capacity and to resurrect communal commitments to family well being (Weick and Saleeby, 1995). Apart from planning a combination of interventions ranging from developmental to ecological it is a necessity to address the current scenario of change at global level.

As we enter the twenty first century, it has become time for the profession to face several challenges from other fields and to reorient itself anew to the social situations like substance abuse and evolve suitable responses. Globalisation as an economic force has created a new world order. It has been applauded by some and
condemned by others, as its impact has not favoured the lot of the majority. Social problems have emerged due to incidence of poverty and deprivation in many parts of the world. High unemployment, family disintegration, poverty, despair, violence and drug abuse are common (Midgley, 1997). Substance abuse significantly contributes to the global burden of illness, disability and death. Alcohol alone accounts for 3.5 percent of the total of all Disability Adjusted Life Years (Murray and Lopez, 1996) lost to disease and disability in the world. Both developed and developing countries are affected by this burden.

Social work needs to become international in terms of dealing with such global issues affecting the developed and developing countries. It should also be collaborative and not unidirectional. Currently such an approach lacks widespread support in Social Work. Problems like substance abuse and family violence reveal social workers' best efforts to make the clients aware of the maladaptive cycle, problem behaviour patterns which many individuals appear unable to break. The evidence favouring a natural inclination toward a preventive lifestyle is scant (Schinke, 1997). Of considerable importance is the inclusion of a preventive orientation and a de-emphasis on remediation in social work education and practice. Preventive Social Work includes those programmes, policies, and clinical efforts aimed at helping clients and their families avoid future problems. While preventive efforts are not solely in the ken of professional social workers, prevention can be done effectively by members of other social and mental health helping professions and by most health care workers. However, the professional training ideally positions social workers to develop responsive prevention programmes that address the everyday realities of clients' lives in contrast to treatment and rehabilitation.
Data supporting root causes of problems to which preventive intervention programmes can be applied in the area of substance abuse is scarce. Community programmes will be effective only when they prove themselves scientifically. They should be open to scientific research. Such programmes when evaluated can lend themselves to training programmes.

There is an increased awareness of biological factors in social work practice most evident in areas of health social work. The advent of biochemistry has revolutionized treatment (Kaplan and Sadock, 1995; Sederer, 1991) and social workers have had to respond to the side effects of pharmacological medication. In practice, with problems of substance dependency awareness of the biochemistry of dependency and cognitive, emotional and behavioural correlates are essential for effective social work practice (Meares and De Roos, 1997).

Social work practice in health care especially for substance abuse can no longer be viewed as specialised practice within an acute hospital. Rather, it becomes an approach that fully integrates micro and macro services that transcends settings. Social work in health requires the delivery of broad based social health services to individuals, families and populations within a range of settings, such as schools, work places and community social health agencies to promote social well being (Lowe, 1977). This would be apt for substance abusers and their families.

While adapting these models to social work in health care, the goal is to link individuals, families and groups to a range of health promotion, prevention and treatment services which is a move away from the 'medicalisation' of social problems (Dayaranta, 1992; Hurowitz, 1993). A community-based approach is similar to the social health model for practice that places both individual and population health
needs and problems into a social context. It looks for solutions within the individual, the environment and social health policy. As reported by Fellin (1995) it is designed to increase competence - that is the ability of the members of the community to identify needs and solve problems to achieve goals.

While dealing with substance abusers and their families it is necessary to look from the strengths perspective in social work practice. The strengths perspective demands a different way of looking at individuals, families, and communities. All must be seen in the light of their capacities, talents, competencies, possibilities, visions, values, and hopes, however dashed and distorted these may have become through circumstance, oppression, and trauma. The strengths approach requires an accounting of what people know and what they can do, however inchoate that may sometimes seem. It requires composing a roster of resources existing within and around the individual, family, or community (Saleebey, 1996).

Looking further into community-based social work it is seen that community residents and organisations are enabled to identify and analyse their social health needs and concerns, as well as their strengths. An empowerment model of social work practice (Gutierrez, et al., 1995) can be used to ensure that community members have the capacity (knowledge and resources) and authority, power to make the decisions and choices required for this process. Interventions therefore to promote social functioning must be designed to improve or change the system itself or create changes in other social structures.

A service programme that is universal, comprehensive, integrated, accessible and accountable to support overall well being of the community and its constituencies is required (Specht and Courtney, 1994). For eg. teen pregnancy,
substance abuse, truancy, family violence, physical and mental illness are often interrelated social health issues faced by children, adolescents and adults within communities. Thus, it is essential that these be addressed as a unit rather than as individual issues. Multi-service centre programmes that are built from within the community are targeted to more than one group and are school or community agency based. These are more likely to be effective in preventing many of these social-health problems and in promoting individual and community change (Dryfoos, 1994; Family Impact Seminar, 1991; Kahn and Kamerman, 1993).

Interventions are therefore required to be holistic - both family and community centred social work is to be followed. Social work can be effective in intervening along a continuum of delivery taking into consideration inherent contradictions. In practice, social workers besides being case and community organisers also need to have entrepreneurial approaches and also involve themselves in practice research adding to the knowledge in the field. Substance abuse in the current study can be placed in the context of a social health model. The study is an understanding of the functioning of families of substance abusers in their social milieu.

RELEVANCE OF THE STUDY

Given the magnitude of the substance abuse problem the psychological theories, as causes of the problem seem to fade in the background as it has moved more into the macro level web of illicit trafficking and addiction. The socio-cultural influences and narco terrorist nexus has questioned the adequacy of well-known demand reduction and supply reduction strategies.
The emergence of the HIV epidemic and the implication of associated high risk behaviour among drug dependents has again drawn attention to the substance abuser especially the intravenous drug user. Studies on intravenous drug users using alcohol are reported (Belenko, 1979; Latkin et al., 1994; Kumar, 1997).

The concept of abstinence seems a utopian ideal for many and the need has come for a more realistic strategy to address the HIV epidemic. The harm reduction method has emerged as the latest philosophy in the management of the problems. WHO has advocated the method in its documents cautioning for the impending doom. Methods such as bleach, needle exchange and buprenorphine tablet substitution programmes although controversial are used in many countries.

In the overall management of the substance abuse problem, the family still emerges as one of the main agents of intervention. Many are the stresses that the dependent person undergoes in the whole process. The physical problems, loss of self-esteem, depression, social isolation and stigma are associated with the habit. The family also undergoes considerable stress as these individuals belong to families.

Many researchers have come in defence against the concept of 'co-dependency', which portrays the wife as a sick person who married the alcoholic to fulfil her needs. Extensive research has highlighted the implications of an alcoholic family's influence on the family functioning, development of children and the development of substance abuse in the children. The way it affects the future family functioning of the children has also been focused on.

The families have been much maligned for upholding the secret of alcohol dependence. Research has shown alcohol was known to have adaptive qualities used by families. Studies on family coping are fewer as compared to studies on
pathological family functioning. Drug dependence being a recent phenomenon with trends of usage changing periodically has also lent itself to systematic research in certain aspects. Coping studies in families of drug addicts is fewer. Overall, patterns of coping reveal that families have difficulty following any one pattern of coping.

Jackson (1954) studied coping strategies in early 1950's. Families cope better when social supports have been available. The family as a social support is also crucial in treatment, facilitating recovery. Dealing with the stress of substance abuse in a family member the family develops its own coping strategies. The level at which the family copes is also influenced by the cohesion and communication in the family. Further, this influences the way the family is going to adapt to the condition. Social Work practice currently stresses on the need for awareness and ability to use family strengths during times of heightened transition and stress. However, there are fewer comparative studies of alcohol and drug abuse. Many studies lack a normative sample highlighting the relevance of the current study, which is a step in the direction of answering these research questions.

1. What are the stresses faced by the families of substance abusers?
2. How can the response of the family be portrayed in terms of coping?
3. In combining the stress and coping patterns how does the family adapt to the condition? How is the functioning of the family?
4. How do these families compare on the above parameters in relation to non-user families living in the same community?

These research questions have been raised based on the mammoth literature reviewed in this area. The same has been presented in the subsequent review of literature chapter.