CHAPTER - II

REVIEW OF LITERATURE

HISTORICAL PERSPECTIVE

SCIENTIFIC ORIENTATION TO

ALCOHOL AND DRUGS

AETIOLOGY OF ADDICTIVE BEHAVIOURS

CONSEQUENCES OF SUBSTANCE ABUSE

TREATMENT OF SUBSTANCE ABUSE

STRESS

COPING

FAMILIAL ADAPTATION
Abuse of substances is known from time immemorial. Any attempt at understanding the concept of addiction involves tracing the chronological use of addictive substances. The fact that addictive substances are used in many cultures makes it difficult to eradicate. However, with the advent of modern drugs and the wider implications at the individual, familial and global level the attitudes to substance abuse both alcohol and drugs have been brought into focus.

Both substances - alcohol and drugs by virtue of their pervasive influences have been the subjects of much research in the field of mental health. The studies range from genetic aspects to psychosocial and socio-cultural factors and consequences. The interrelationships of substance abuse to stress, coping and social support are factors very related to the patterns of use and abuse. They influence recovery and adaptation to the condition by individual and the family.

The review of literature gives a picture of the various studies that have gone to build a perspective of substance abuse as a phenomenon. It begins with a historical perspective of the use of alcohol and drugs down the ages with reference to India. Then moving on to a scientific orientation to alcohol and drugs, epidemiological studies of alcohol and drug use in India are presented.

The multi-dimensional aetiology of addictive behaviours is presented next with an emphasis on familial aspects of alcohol and drug abuse. The impact of substance abuse is described through the consequences followed by treatment and prevention of substance abuse. The next part deals with the theoretical dimensions of stress, coping and familial adaptation, placing in perspective the need for the present study.
HISTORICAL PERSPECTIVE

The word 'alcohol' comes from the Arabic term 'al-kuhl' meaning essence (Channabasavanna, 1989). An Arabian alchemist developed the process of distillation around 800 A.D. By the thirteenth century the aqua vitae (water of life) was used as a medicine for prolonged life and youth. Aqua vitae is known as brandy, deriving from the Dutch word 'brandewijn' meaning burnt or distilled wine.

India like many other countries has a long history of use of intoxicating drinks despite being referred to as a 'dry' culture. Soma and sura were drinks known from the Vedic period. The soma sacrifice was the centre of the Rig Vedic ritual. Soma juice was a sacrificial drink conferring immortality on Gods and men. It was called 'amrita', the 'draught of immortality'. 'Sura' was the drink of the people of the sabha more intoxicating than the sura. 'Masara' was another beverage commonly known at that time (Majumdar, 1971).

Down the ages intoxicating drinks were in use in different degrees. Besides alcohol, cannabis, opium and its derivatives was also common in India. The use of cannabis in India dates back to 800 B.C. Bhang was used in the religious context (Kalant, 1972). It was common among sadhus, fakirs and mendicants (Verma, 1972). It was a favourite drink of Lord Shiva (Gopinath and Praveen, 1991). Ganja was smoked in the villages where there was social sanction and facilitated a feeling of fellowship.

It is reported that Alexander The Great introduced opium into India in 300 B.C. It received a lot of boost under the British as an important trade commodity (Charles, 1992). Among the Indian states there's longstanding use of opium in
Rajasthan as a pastime for youth, as a reprieve from the worries and anxieties of drought. It was also used as a medicine to mitigate the various health problems. It was considered deviant only when the addicted individuals sold goods or property to procure opium (Ganguly et al., 1995).

The Indian systems of medicine have been known to use drugs. Ayurvedic pharmacology has used opium, cannabis and other drugs since about 1500 A.D. (Anthony et al., 1994).

Historically use of alcohol, cannabis and opium was regulated through well-defined contexts of usage and by traditional mechanisms of social control (Sethi et al., 1975; Ganguly et al., 1995). However, excessive use was condemned in the past even when it was accepted. Thus alcohol and drugs such as opium and cannabis have stood the test of time and have lightened the life of man bringing him pleasure and relief from pain and distress.

SCIENTIFIC ORIENTATION TO ALCOHOL AND DRUGS

The major conceptualisations of alcoholism have varied between viewing excess in drinking behaviour as a moral problem and as a disease. The medical world of the nineteenth century in general, harshly condemned the alcoholic and viewed inebriates as 'vicious' rather than diseased (Miller, 1980).

In the mid-nineteenth century, medical problems and social factors giving rise to alcoholism were recognised. Jellinek was one of the early pioneers of research in the 1930's. He gave the disease concept of alcoholism as a progressive medical disease. The modern alcoholism movement is centred on this (Page, 1988).
Edwards and Gross (1976) proposed a new and broader conceptualisation of the Alcohol Dependence Syndrome different from Jellinek's. It differed from the standard definition of dependence in the United States of America as in the Diagnostic and Statistical Manual (DSM-III, American Psychiatric Association, 1980). The Diagnostic Statistical Manual-III Revision (DSM-III R, American Psychiatric Association, 1988) is an attempt to bring the DSM classification closer to Gross and Edwards' concept and the WHO's International Classification of Diseases, ICD. Today it is accepted that an individual can drink in a damaging way without being physically dependent on alcohol (Abraham and Chandrasekaran, 1997).

The widespread nature of the problem and growing scientific interest in assessing the magnitude of the problem prompted epidemiological studies. There is no national prevalence study available in India. Regional general population surveys have found that use among men varies from 16.7 per cent to as high as 58.3 per cent, varying by the degree of urbanization as well as by region. Using an average of 60 per cent male abstinence and female abstinence, per capita consumption of adult drinkers is approximately nine litres of alcohol (WHO, 1999).

Studies from the late 1970s and early 1980s reported a prevalence rate of 19 per cent to 32.9 per cent for general population as ever users or having used at least once in the last one year (Mohan et al., 1978; Lal and Singh, 1979; Varma et al., 1980; Advani et al., 1981). Deb and Jindal (1975) reported a prevalence of 74.2 per cent only for the adult male population. Similarly Sethi and Trivedi (1979) reported of 82.5 per cent user at least one month in the last year. Early nineties large
population studies at Bangalore (ICMR-CAR-CMH, 1990) and at Maharashtra (Bang and Bang, 1991) reported of 1.15 per cent and 5 per cent respectively to be addicted to alcohol. In all the studies males were predominant, 15 – 25 years was the initiating age. The proportion of female consumers is very low in India (Ray and Sharma, 1994; WHO, 1999).

Studies among student population (Dube et al., 1978; Varma and Dang 1980; Mohan et al., 1981) being the next set of studies concluded that 12.7 per cent of high school students, 32.6 percent of university students, and 31.6 per cent of non-student young people were using alcohol. Medical students in the same period reported much higher prevalence between 40 and 60 per cent.

The studies listed above are not strictly comparable because of differences in the sampling method, data collection and definition of terms used in terms of ever used, occasional, moderate or heavy use etc. (Singh, 1989; Isaac, 1995).

In Madras (Chennai) studies on prevalence of alcohol use has been estimated to be 16.67 percent of the male population (Ponnudurai et al., 1991). Among adult males in rural areas 26-50 percent were alcohol consumers (Chakravarthy, 1990). Mathrubootham (1989) found that 33 percent of the rural males were current consumers of alcohol.

The epidemiological studies in relation to drug abuse in India revealed that the drugs in common use in India were opium, ganja and bhang (Elnagar, 1971; Dube, 1972). General population studies conducted from 1971-1980 by different researchers in Agra, Lucknow and Punjab reported varied rates from 0.2 to 29.38%. The problem of drug abuse existed in both urban and rural areas. The commonest
drugs abused were tobacco, alcohol and cannabis. Cannabis use seemed to be more in North India (Channabasavanna, 1989).

Student surveys in seven universities sponsored by the Department of Health and Family Welfare (GOI, 1977) revealed the urban trends. The note of caution by the National Committee also initiated a series of studies on student population from 1970 to 1984. Twenty-five cross sectional studies among college students from different parts of India at various points of time reported the prevalence rates to range from 5% to 56.2%, depending on the inclusion or exclusion of alcohol, tobacco or painkillers. The figures varied among different religions. The rates were found to be higher among medical students. Males were found to abuse more as compared to women and most were unmarried. Tobacco, alcohol and painkillers, tranquillizers and cannabis appear to be commonly used (Channabasavanna, 1989).

Other studies also showed that cannabis use/abuse was more common than opiates (Venkoba Rao, 1978; Gangarade, 1981). The studies have also highlighted that there is existence of poly-drug use in several instances (Venkoba Rao, 1978; Singh, 1979; Veeraraghavan, 1981; Sethi et al., 1984). In a study of drug abuse among non-student youth labourers, Gupta et al., (1987) reported use of tobacco, alcohol and cannabis among factory workers, rickshaw pullers and railway coolies.

In the epidemiological research for drug use, the most commonly used methods of data collection have been self-reports affecting the precision of the study. Many of the studies were among student populations and are not generalizable to broader populations. The generalizability is reduced further due to use of available rather than random sampling and lack of similarity between the types of sampling
tools. Channabasavanna (1989) has reported the sampling methods employed in
different studies and their appropriateness. Despite these methodological limitations,
the historical and epidemiological trends revealed the predominance of alcohol and
drug use and the emergence of alcohol and drug abuse as a problem. However, with
the changing scenario of drugs the current trends can be seen.

The Ministry of Welfare carried out a wider assessment of the current trends
of drug abuse in 33 cities with the following objectives: 1) to ascertain the nature and
extent of drug abuse; 2) identify the major socio-economic factors contributing to
drug abuse; 3) to identify areas and population groups affected and 4) to ascertain the
adequacy of available services. For each city two samples were drawn from addicts
and informed persons. Two separate schedules were prepared to elicit responses from
the two categories. The report showed that drug addiction was prevalent in varying
degrees among all religions and caste groups; most of the drug abusers were literate;
the age group between 16 to 35 being worst affected; marital status had no
consequence in drug abuse; a significant proportion came from the lower strata;
occupationally non workers and menial workers accounted for a large chunk. Within
these general trends an ample evidence of regional variation was obtained (GOI,

Buprenorphine:

Buprenorphine is a semi-synthetic opioid derivative effective in the treatment
of drug addiction and potentially addictive (Jasinski et al., 1978; Lewis et al., 1982;
Mello et al., 1982; Jaffe and Martin, 1985; Fudala et al., 1990; San et al., 1992).
India has been witnessing an upsurge of heroin abuse, and abuse of injectible drugs,
especially buprenorphine (Basu et al., 1990; Chowdhury and Chowdhury, 1990; Singh et al., 1992). The use of the latter substances is reported primarily in an intravenous and intramuscular mode.

**Poly-Drug Use:**

Clayton and Ritter (1985) reviewed many studies of drug use and found that, 'more often than not, the persons who are using drugs frequently, are multiple drug users'. This appeared to be true for both frequency and quantity of licit substances as well as use of illicit drugs.

Use of drugs among teenagers is typically not limited to one specific substance but often involves use of various drugs. This is particularly true during adolescence and for those who use illicit drugs (marijuana, cocaine) but it is also documented among young adults (Newcomb and Bentler, 1988 a, b) and adults (Newcomb, 1992) as well. A few emerging trends of drug abuse in India is that cough mixtures and medicines are being abused by a large number of addicts in the Northeastern part of India (GOI, 1992). The common brands abused by addicts are phensedyl, corex, phenergan, valium, nitrazepam etc. Buprenorphine, dextropropoxyphene are also abused in several parts of the country.

Medicinal drug abuse is rampantly increasing in many metropolitan cities including Mumbai where majority of the addicts belong to the poorer sections of society and nitrazepam is the commonest pharmaceutical drug abused. The National Addiction Research Centre, Mumbai statistics for the years 1990-1996 reported thirty nine percent have been abusing medicinal drugs along with brown sugar and/or cannabis (Shetty et al., 1996). Of concern is the recent abuse of substances by child labourers. Of 300 child labourers 45% had used some substance- tobacco smoking,
chewing, snuff, cannabis and opium. The common reasons identified were changes due to industrialisation, urbanisation and family problems (Bansal and Banerjee, 1993).

Moving from a historical, epidemiological perspective the next is the genetic aspect that has been researched extensively since alcoholism ‘runs in families’.

AETIOLOGY OF ADDICTIVE BEHAVIOURS

Genetic Studies:

The observation that alcoholism is familial is supported by many family studies though few have been conducted in a scientifically rigorous manner (Guze et al., 1986; Merikangas, 1989). However, the increased rate of alcoholism did not distinguish between genetic and environmental factors.

Twin studies were used to separate nature and nurture (Kaij, 1960; Hrubec and Omenn, 1981; Gurling et al., 1981; Pickens et al., 1991; Sher, 1991; Kendler et al., 1992). They emphasized a genetic vulnerability for alcoholism but also emphasized importance of environmental factors.

Goodwin et al. (1973), Cadoret and Gath (1978), examined individuals reared by unrelated parents and reported increased rates of alcoholism in adoptees with an alcoholic biologic parent. These data suggested a genetic component to alcoholism.

Adoption studies do indicate critical importance of an alcoholic biologic background in predicting offspring liability to alcoholism (Goodwin, 1988; Searles, 1988; Sher, 1991). The studies differ in the extent to which environmental variables are implicated (Sher, 1993).
The family, twin and adoption studies indicate genetic vulnerability and implicate an important role for environmental factors in the development of alcoholism associated with a family history of alcoholism.

Multi-Faceted Aetiology:

Many are the theories on the aetiology and processes of alcoholism and drug dependencies. In searching for the aetiology no single answer is appropriate instead a multi-faceted aetiology is what is accepted. It is of importance to know why human beings abuse themselves by abusing drugs. The pharmacology and physiology of physical dependence and tolerance to drugs are explored but no one theory based on bio-physiological factors has emerged for neither alcohol nor drug abuse.

Several researchers have contributed to the theoretical understanding of aetiology from psychoanalytical (Williams, 1976) tension reduction (Nathan et al., 1980) and personality perspectives (Jones, 1971; McClelland et al., 1972; Mohan et al., 1995).

Among environmental factors in the aetiology of alcohol misuse, studied under factors affecting availability of agent and factors affecting vulnerability of host, availability of alcohol is a key factor influencing consumption of alcohol. Economic availability refers to the price of alcohol. Social availability refers to the influence of advertising on alcohol consumption though results are inconclusive as shown by Moskowitz' review before 1989. Critics argue that advertising even if it does not increase, maintains levels of drinking and appeals a lot to youngsters. Physical availability refers to the number of outlets, hours of availability and rates of consumption (Saunders, 1985).
With reference to occupation research indicated that heavy drinking tended to be more common in certain types of occupations (for eg. those in the alcohol industry and armed forces) exhibit an organisational structure characterised by factors such as availability of alcohol, social pressure to drink, separation from normal relationships, freedom from supervision and collusion from colleagues (Plant, 1979; Gorman, 1988).

Maritime population which includes merchant, marine, fishery, naval and oilrig workers is a high-risk group. Factors such as long absence from home and family, loneliness and a 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).

Similarly for drug abuse dynamic theories (Freudenberger, 1973), behavioural theory (Wikler, 1965) has been described for drug seeking behaviour. The general deviance syndrome (Newcomb and Bentler, 1988,a; Newcomb and Mc Gee, 1991; Mc Gee and Newcomb, 1992) concluded that alcohol and drug use and abuse are often components of a cluster of behaviours and attitudes that form a syndrome or lifestyle of problem behaviour or general deviance.

The risk factor methodology is a recent methodology applied to the study of alcohol and drug use or abuse (Bry et al., 1982; Newcomb et al., 1986; Scheier and Newcomb, 1991 a, b) and has proven to be informative. This approach suggests that the more risk factors someone is exposed to that encourage alcohol or drug use, the more likely he or she will use or abuse these drugs. This approach reflects an additive model of increasing risk exposure. The difficulty with this methodology is that it
lacks the careful understanding of the problem that well-grounded theories can provide.

**Public Health Model:**

A public health model in its application to drug abuse describes how some people grow up in endemic areas, pockets in city slums where anti-social activities, drug peddling and use of illicit drugs are 'normal'. Such people may socialize into drug use but the majority, become individually infected by others. This approach suggests that the more risk factors someone is exposed to that encourage alcohol or drug use, the more likely he or she will use or abuse these drugs. This approach reflects an additive model of increasing risk exposure (Ko Ko, 1995).

**Parental Modelling:**

Epidemiological literature linking parent and child drinking practices has emphasized the role of observational learning in the development of drinking behaviour (Cahalan et al. 1969; Webster et al. 1989). Rollins and Thomas (1979), Maccoby and Martin (1983) and Martin (1987) have emphasized the socialization model. Most important, inadequate parenting characterized by lack of affection and/or high levels of criticism and hostility, lax or inconsistent discipline and supervision, and general lack of involvement - provide the foundation for the development of an aggressive, antisocial behaviour pattern. Such a pattern evolves over time into a behaviour pattern characterized by early peer rejection, poor academic performance, by continuing expressions of delinquent acts, alcohol and drug abuse and association with deviant peers.

Most, though not all studies show raised rates of alcohol use among teenage children of alcoholics (Johnson, 1989). Catalano, (1992) identified various factors as
relating to the induction of children into drinking including parental and sibling alcohol use, positive parental attitude to substance use and ‘lax family supervision’. Close family involvement and mutual trust are protective. Over the years, support has developed for this child socialization model as specifically related to the development of adolescent alcohol and substance abuse. Barnes (1990), Harburg et al. (1990), observed that parental modelling of alcohol abuse studies are not conclusive and further studies are needed. Many clinicians and writers assume a strong relation between family violence and parental alcoholism. Recent reviews paint a less clear-cut picture (Hamilton and Collins, 1985; West and Prinz, 1987).

**Familial Aspects:**

Scott (1970) and Black (1981), offer well-designed conceptualisations of dysfunctional roles that children from alcoholic homes assume. Children growing up in alcoholic families seldom learn the combinations of roles, which mould healthy personalities. Instead, they become locked into roles based on their perception of what they need to survive and bring stability to their lives.

From an intergenerational perspective, unresolved issues are carried from one generation to the next. The children carry anxiety about themselves into relationships and this lack of individuation dysfunctionally impacts the patterns of relationships with friends, lovers and children (Wolin, 1980).

In a longitudinal study Kandel and Andrews (1987) analysed the relative importance of peer versus parent effects in adolescent drug use. They found peer influences were stronger predictors of drug use than are parental influences. Whereas parent effects account for more variance in initiation of alcohol use than do peer influences. The total effect of friends' drug use is very large, which was direct.
The relationship between family cohesion and the socio-emotional adjustment of youth has been explored in numerous studies (Smart et al., 1990; Novv, 1992; Koopmans, 1993). These studies generally found that adolescents were at risk when family cohesion was low. Measures of low family cohesion were correlated with socio-emotional problems, juvenile offences and drug and alcohol abuse among adolescents. Economics is a primary factor contributing to low family cohesion. A decline in family life and parental supervision is inversely related to increases in extracurricular activities, antisocial behaviours and substance abuse among adolescents (Smart et al., 1990; Shilts, 1991).

With a backdrop of changing family dynamics and roles, close, tight-knit families who were able to maintain their integrity, buffered the members against the stress of change. Cohesive families may also serve other functions that enhance individual coping. For example Voydanoff and Donnelly (1989) noted that families whose members are emotionally close serve as a resource for social support as well as model for appropriate problem-solving skills. Because of the degree of change, family cohesion has been difficult to maintain and has required stronger commitment among members.

Brook's longitudinal study of adolescent drug use focuses on family variables as the major psychosocial influence in the development of drug use and abuse patterns (Brook et al., 1990; Brook and Brook, 1990). Several findings of this research are important.

First parent-adolescent relationships involving both mothers and fathers were significant predictors of adolescent drug (marijuana) use. Second, adolescent personality was a robust predictor of adolescent drug use in particular, sensation-
seeking, rebelliousness, and tolerance for deviance. Third (perceived) peer drug use was the strongest predictor of adolescent drug use. Fourth, parent conventionality and parent adolescent attachment served protective functions, offsetting the risk of drug use associated with perceived peer drug use. Fifth, childhood factors (e.g. irritability, temper tantrums fighting with siblings, maternal non-involvement) were significantly related to adolescent drug use.

The above study though brings in the parent adolescent relationship in drug use or abuse does not address the family adaptability to substance abuse during the above mentioned life cycle stages.

CONSEQUENCES OF SUBSTANCE ABUSE

Physical Health:

Dependence on substances is a serious social, psychological and health problem. It is a complex disorder with far reaching harmful effects on family, work, and society as well as on physical and mental health of the alcoholic himself. Drugs including alcohol and tobacco may cause problems related to health, behaviour, family, work, money and the law. Sedatives and alcohol damage the liver, stomach, brain and nerves thereby causing loss of memory, stimulant and hallucinogenic drugs produce mental illness with suspicious, excessive fears and depression (WHO, 1993).

Persons dependent on drugs, fall sick more frequently than others. Their nourishment is often poor, so they are apt to contact various physical illnesses. A common problem is infection of the skin, urinary tract or respiratory system. Various accidents are also associated with intoxication. Some illnesses are related to
the way in which the drug is taken. Injection of drugs can damage the blood vessels causing widespread infection, drug ingestion can cause stomach disorders.

Cramps, vomiting, diarrhoea, sweating and sleeplessness are the withdrawal symptoms associated with opiate group of drugs. Parenteral drug abusers predominantly use their veins as the main vessels into which the drug is injected. Sharing of injection equipment is present among intravenous drug users exposing them to several health risks such as HIV infection. This is one of the most harmful consequences of drug use.

It is important to observe that prevalence of hepatitis B virus (HBV) also is high among IDU’s and is estimated at 33% in a community-based sample (Kumar et al., 1995).

Mental Health:

Drug abuse very often causes emotional and psychological problems. Memory may become poor and the personality may change or deteriorate. Depression or nervousness may occur together with irritability, changeable moods and withdrawal from social contact.

Cannabis products also lead to mental illness or general loss of interest among users. All these health and psychological problems not only affect the individual user but the family and society at large. A number of studies indicate high rates of DSM-III criteria depressive disorders in opioid addicts with rates two to three times higher than in the general community samples (Kosten, 1982).

In a study on the influence of alcohol dependence on interpersonal relations and adjustment it was seen alcohol dependent subjects showed poor adjustment with regard to sense of personal freedom and sense of personal worth. They felt
alienated, tended to withdraw from others and were lacking in social standards. Antisocial tendencies lead to frequent quarrels and disobedience, which along with poor social skills lead to disturbed relations in the family, with the community and in occupational spheres. On the whole it lead to personal and social insecurity and hence to maladjustment. Loper et al., (1973) study findings also support the above. Senthilnathan et al., (1984) reported of maladjustment in alcohol dependent individuals as compared to non-drinkers. Bartha and Davis (1983) also reported that an alcoholic life might be complicated by psychiatric and emotional problems and stress in the family. In a study of psychosocial sequelae of 100 alcohol dependents mood disorders, depression and anxiety were found (Shah et al., 1996).

Suicide and Death:

Gruenewald et al. (1995) did a study on suicide rates and alcohol consumption in the US between 1970-89. An association between heavy alcohol consumption and suicide has been shown by Tsuang, (1978), Black et al., (1985) when compared with general population, retrospective studies of the behavioural concomitants of suicide attempts (Robins, 1981; Whitters et al., 1985) and psychological autopsies of suicides (Shaffer et al., 1992). However, the role of associated psychopathology and lack of social supports through loss of family integration makes it ambiguous.

Similarly several studies have shown substantiated proportions of alcoholics among suicides (Murphy, 1992). Depression in the individual could be inducive of both alcohol abuse and suicide (Roy and Linnoila, 1986; Norstrom, 1990). In the Indian setting suicide attempts were observed in alcohol dependent patients by Ponnudurai and Jayakar (1991), Patel (1993), Shah et al., (1996).
The field of drug addiction is subject to fads and fashions. While overdose-related deaths among opiate users were a major concern in the 1960's and 1970's (Pierce-James, 1967; Bewley et al., 1968), very often such deaths are accidental. Risk factors for death due to overdose among opiate users are the level of purity of street heroin and alcohol use (Ruttenber and Luke, 1984; Oppenheimer et al., 1994), relapse following abstinence (Haastrup and Jepsen, 1988), recent treatment dropout and social isolation and possibly low educational status and longer history of use (Davoli et al., 1993). Methadone maintenance appears to protect against death from overdose (Caplehorn et al., 1994).

Violence and Crime:

The relationship between alcohol, drug abuse and criminal behaviour is highly complex and difficult to evaluate because of methodological flaws in existing studies, including multiple definitions of alcohol use (dependence, abuse, intoxication, ingestion) lack of uniform definitions of crime, biased sampling, lack of distinctions among subgroups of alcohol users and offenders (Greenberg, 1981). Evidence suggests that substance use (alcohol, cocaine, and other drugs) contribute to violent acts. Watts and Wright (1990) found that individually and in combination various substances strongly predicted violent behaviour among Mexican, American, white and black youth.

Marital assault has been shown to have a high connection with alcohol consumption (Gondolf and Foster, 1991; Shah et al., 1996). Other models propose that concurrence of alcohol ingestion and violence is interactive and context-related (Bradford et al., 1992; Samson and Harris, 1992; Tardiff, 1992; Milgram, 1993). Alcohol may tend to provoke violence when it is combined with a third variable such
as frustration and sleep deprivation. However, despite some contradictory findings (Franklin et al., 1992), the preponderance of studies indicates that alcohol contributes to aggressive and violent behaviour.

In many countries or regions possession or consumption of a drug may be an offence, so users commit a crime by being users. Production, procurement, transportation and distribution of many drugs entail illicit distillation, smuggling and peddling. Second drugs impel users or addicts to commit 'money-making crimes' so as to maintain an expensive drug habit (Shrestha, 1992). A great deal of money often changes hands in the transaction of drugs and those involved in these transactions are not averse to cheating or violence.

**Family Functioning:**

Nearly all family functions have been described as malfunctioning where one or both parents is an alcohol abuser (Schulsinger, 1986; Johnson, 1990; Sher, 1991) including higher intra-family conflict, impaired organization, disruption of family rituals, impaired mother-child attachment (Logue, 1990), more family economic difficulties and family breakdown.

Sher's (1991) review found consistency between several studies using the Family Environment Schedule (FES), indicating lower levels of family cohesion, expressiveness, intellectual-orientation and higher levels of family conflict. These same measures did not differentiate families of recovered alcoholics and non-alcoholics suggesting that family disturbances were the effect rather than the cause of alcoholism.

Bowen (1978) contends that some families are facilitative of development (and adjustment) while other families establish a model that inhibits adjustment and
fosters dysfunction. The developmental patterns of children of alcoholics can reflect for a lifetime and beyond, the emotional climate of the alcoholic family of origin. Crespi (1990) noted that in alcoholic families, children could become tools for parental maltreatment a concept suggested by Bowen (1978), and that the tolerance for individuality that exists within functional, healthy families is distorted by alcoholic family patterns.

Alcoholic family systems, marked by a lower level of differentiation emphasize fusion, where individuals can lose their sense of self in the relationship. They do not develop the fluid flow from autonomous individuality to intimate connectedness so necessary for highly individuated development. In other words, in the alcoholic family children can become psychological levers designed to serve the family in unhealthy ways as targets for alcoholic blame, another a crutch for the alcoholic to lean on, another a sexual magnet for adult gratification and yet another may be discarded like trash (Crespi, 1990). In alcoholic families hidden scars and wounds no less painful than the cuts and bruises experienced from other devastating encounters are found.

Wolin et al., (1979), using semi-structured interviews assessed the extent to which family rituals (celebrating holidays, taking vacations) were disrupted by the drinking of the alcoholic parent. These findings led them to conclude that alcoholism is a family illness, with compelling patterns that support its study from a family culture perspective. This can protect or precipitate the children of alcoholics becoming alcoholic themselves (Bennett and Wolin, 1990).

Woititz (1983) observed that the family of the alcoholic is caught in the consequences of the illness and also becomes emotionally ill. Woititz (1985)
highlights the fact that alcoholism affects a family member's ability to form intimate, mature, satisfying relationships. Alcoholism is reported to destroy the parent-child bonding process and significantly impairs interpersonal relationships for children from alcoholic families. The issues raised highlight the distinctive ways in which alcoholism distorts lives in terms of attachments, professional and personal relationships, psychological well-being, problem-solving strategies and affective styles (Black, 1981; Woititz, 1983; Crespi, 1990).

Sher (1991), reported some evidence to suggest that family disruption is related to difficulties in adult adjustment among children of alcoholics, however additional research is required to prove it. Drinking impairs performance as a parent, spouse or partner and as a contributor to household functioning. Drinking before coming home or at home can impair functioning. Trying to reason with an intoxicated family member is likely to be an exercise in frustration. The drinking may also have put the drinker in a dangerous or withdrawn mood.

Drinking also costs money and can totally deplete the resources of a poor family, leaving other family members destitute. Continuing patterns of drinking offer the threats to family life; but particular intoxicated events can also have lasting consequences, through home accidents and family violence (Room, 1998). Cultural variations in expectations about family role performance will influence the extent of reaction by others to the drinker.

Alcoholism has the worst impact on the financial situation in the family. The majority of the study samples were from lower middle class and middle class, where the family found it very difficult to make both ends meet. In India when a woman gets married she brings with her gold, silver, vessels, sometime even
furniture as her dowry. Her dowry is her social security because most of our women do not work and are not financially independent. In many cases, the husband either pawns or sells his wife's dowry in order to pay for his liquor. The loss of her dowry is a traumatic experience for the average Indian woman, because she now has nothing of her own to fall back on. Many women in this position are forced to go out and seek work to help support the family (Ranganathan, 1983).

Children of Alcoholics (COA):

Several authors refer to COA's as forgotten children (Giglio, 1990). Families of COA both create stress for the child and fail to protect the child from outside stress. Intra family stress is recognized as a significant morbid influence on the children, for psychological and physical health (Silvia, 1990).

Life events are external stressors and Roosa (1990) examined these as risk factors for the genesis of depressive and anxiety symptoms in COAs. COA status was linked to children experiencing more negative life events and negative life events were linked to symptom production.

TREATMENT OF SUBSTANCE ABUSE

In the alcohol field, alcoholism has transformed from a moral to a medical problem. This conversion has been seen as a necessary prerequisite for the transfer of responsibility for alcoholism treatment from the judicial system into the medical establishment. Thus, alcoholism is viewed as a disease process with aetiology, a set of symptoms, a typical course and a predictable prognosis. The treatment community has widely embraced abstinence-based approaches that are closely related to a
disease model of substance abuse problems (Blume and Roman, 1985; Weisner and Morgan, 1992; Weisner and Room, 1984).

Diwan (1990) argued that five distinct ideologica\ldots related treatment and prevention currently exist (1) the medical model (2) AA 12 step-model (3) socio-psychological approach (4) social learning approach (5) public health approach.

Factors Influencing Treatment:

Looking at factors prompting treatment it was found that people in treatment believed they had more severe drinking problems than did untreated people (Finlay, 1966; Pfeiffer et al., 1991). The beliefs of many treatment providers is that alcoholic people seek treatment because of problems with one or more of the four "L.'s" - liver, lover, livelihood or the law (Weisner, 1986). The most powerful predictor of seeking help was the number of life areas negatively impacted by drinking (Corrigan, 1973; Mulford and Fitzgerald, 1981; Hingson et al, 1982; Rees et al., 1984; Shackman, 1984; Humphreys et al., 1991; Pfeiffer et al., 1991; Bannenberg et al., 1992).

Psychological distress in the form of depression and psychiatric symptoms were linked to treatment entry (Woodruff et al., 1973; Hingson et al., 1982; Helzer and Pryzbeck, 1988). The other facet of psychological distress examined was self-derogation (Corotto, 1963; Gross and Adler, 1970; Matefy et al., 1971; Charalampous et al., 1976).

Both chronic strains and acute stressful life events may precipitate contacts with alcoholism treatment programmes (Thom, 1987). Focussing on both stressors and problems associated with drinking, Weisner (1990a) found that drinking while
driving and traffic accidents, arrests for criminal offences and job and health-related events as major factors in treatment seeking.

Advice from others to seek treatment is a 'cue to action' (Finlay, 1966; Weisner, 1990b). Facilitative factors also played a significant role in treatment entry. People were more likely to enter treatment if they had previously sought help for their drinking problem. Life stressors are unlikely to prompt problem resolution unless the person sees them as linked to substance abuse in a way that arouses a specific need for change (Ludwig, 1985).

The number of studies on treatment and outcome of alcoholism from India are few and deal with abstinence rates (Venkoba Rao, 1981; Bagadia et al., 1982; Sharma and Murthy, 1984; Abhyankar, 1986). Detailed descriptions of approaches like family/marital therapy and their long-term efficacy are totally lacking (Desai, 1991).

**Treatment of Alcoholism:**

Treatment of alcoholism is based on several processes such as evaluation of the patient, screening, assessment-psychiatric, psychosocial, physical, laboratory investigations, assessment of motivations and analysis of relapsing conditions. A multi-modal approach incorporating pharmacological and psychosocial modalities of treatment has become the mainstay of management of alcohol related disabilities. Treatment methods should cater to the individual needs of the patient rather than subjecting different patients to the same treatment. Detoxification, pharmacotherapy and medical management, counselling, education, group therapy, marital/family therapy, antidipsotropic medication, self help group, relapse prevention therapy, anxiety and stress management, aversion and social training are the different
modalities used. A multidisciplinary team is usually involved, such as psychiatrist, physician, social worker, psychologist, and psychotherapist, counsellors and trained nurses.

Traditionally de-addiction units dealing with alcohol dependence have offered inpatient service with emphasis on group involvement and they aimed at total abstinence. In recent years, there has been a shift away from the concept of inpatient and total abstinence to outpatient treatment and controlled drinking.

Studies comparing results of inpatient and outpatient programmes have generally failed to show significant differences in the setting of treatment (Miller, 1986; Cole, 1981). Outpatient treatment is worth accepting for suitable patients (Desai, 1991). Fuller et al., (1986) using a randomised, controlled, blind study design found that disulfiram did not enhance the attainment of continuous abstinence more than outpatient counselling alone, nor did it delay time to relapse or improve social stability.

Behaviour therapists have recognized the importance of teaching new, adaptive coping skills to patients who engage in dysfunctional behaviour. A number of studies have demonstrated the benefits of teaching coping and other skills (Ferrell, 1981; Oei, 1980; Oei 1982). Others have not confirmed these findings (Sanchez-Craig and Walker, 1982).

A considerable literature describes group therapy techniques in the treatment of alcoholism (Vanicelli, 1982) but a few evaluation studies support its efficacy. A study by Oei and Jackson (1980) compared group with individual therapy. Improvement was found only among those patients given social skills training and those trained in a group setting improved more than those treated individually.
Alcoholics Anonymous (AA) is regarded as the most useful resource for treating alcoholic and other substance users, yet the research literature supporting its efficacy is not extensive. Attendance at AA tends to be correlated with long-term abstinence (Polich, 1981) but causal relationships cannot be readily inferred from these studies. The few random assignment studies conducted (Ditman et al., 1967; Brandsma et al., 1980), did not indicate that AA is more effective than other types of treatment.

A general approach focuses on frequent aftercare contact in the period following detoxification or inpatient treatment. In general, affiliation with aftercare groups is associated with better treatment outcome (Costello, 1980).

Relapse is an inevitable part of the treatment and aftercare process. However, an important differentiation has been made between an occasional or one 'lapse' on part of abstinent patient and relapse to pathological or dependent pattern of drug use (Marlatt, 1984).

Negative mood states have been implicated for relapse in the literature (Litman, 1983; Marlatt and George, 1984). Indicators or predictors of relapse like stressful life events need to be looked for and appropriate intervention planned (Desai, 1991).

In a psychosocial study of relapse after two months of abstinence it was found that the relapsed group had sensation seeking, interpersonal conflicts with spouse and misunderstanding with family members as relapse precipitants (Singhal and Nagalakshmi, 1992). Raj et al., (2000) studied relapse precipitants in opiate addiction in a community treatment setting and found that sleep disturbances, body ache and craving, sadness, family conflict and peer influences as common reasons for relapse.
Drug Treatment:

Moving on to drug treatment it was seen that up to the 1960's treatment for opioid addiction was synonymous with prolonged hospitalisation (Jaffe, 1989). The picture changed in the 1960's with the introduction of new drugs of which methadone came to occupy the prime position. Pharmacological agents have been used for long-term treatment of dependence for quite sometime.

The safety of methadone is established beyond any doubt (Kreek, 1979). Patients have taken daily doses for 18 years without developing problems (Senay, 1985). Clonidine has also been used to treat opioid addiction. It was not presumed to have any abuse potential, but cases of clonidine addiction have been reported (Schant, 1983).

Buprenorphine emerged for use for opioid detoxification (Jasinski et al., 1978; Mello and Mendelson, 1980) but its clinical use for this purpose has been fairly recent. However, its abuse potential is so high that it is not advocated freely. The distinction between 'pharmacological drugs' and 'drugs of abuse' becomes quite difficult, overlapping and blurred at times making it's application controversial (Desai, 1987).

The issue of treatment versus cure still remains alive for long-term management of dependence. The non-availability of a curative method for dependence or addiction is a fact that compels professionals to set other realistic goals (Desai, 1991).

Legal substitution of morphine, raw opium or heroin with another opioid which is prescribed medically has been practiced in one or the other form in various countries over the last century (Senay, 1989) including experience with opium
registry in India (GOI, 1977). This approach called Medical Distributive Model was considered essential for patients with long-term dependence, past record of unsuccessful treatment attempts and no possibility of achieving a drug free life style in the future.

Family treatment of drug abuse started in the 60's and Stanton was the first to review it. The family treatments tried were marital treatment (Wellisch et al., 1970; Polakow and Doctor, 1973; Gasta and Schut, 1977), group treatment for parents (Mason, 1958; Ganger and Shugart, 1966; Amendolara, 1974), concurrent parent and in-patient treatment (Wolk and Diskind, 1961; Caroff et al., 1970; Winer et al., 1974), treatment with individual families (Catanzaro, 1973; Wellisch and Hays, 1973; Huberty, 1976), out-patient oriented treatment (Bratten, 1974; Hirsch and Imhof, 1975; Frederickson et al., 1976; Ziegler-Driscoll, 1977), sibling oriented treatment (Coleman, 1976), multiple family group therapy (Klimenko, 1968; Webb and Bruen, 1967-68; Alexander and Dibb, 1975) and social network therapy (Callan et al., 1975; Speck and Atteave, 1973).

These different studies describe their treatments and successes rather than registering their efficacy. Multiple family therapy, group therapy for parents, out patient oriented therapy with individual families showed more promising results.

Families of drug abusers have often foisted their addicted members on the treatment system thereby abdicating responsibility. Therapists also accepted this yoke. The author observed that we must help families to feel more competent to change their patterns and care for their own. Blum et al., (1972) stated that family is a force that helps resist or exaggerate the stress of other environmental factors. There is a need to find ways to strengthen the resistances and minimize the exaggeration.
Family Treatment Approaches:

The attention given to family therapy approaches to alcoholism has been recent and disproportionately low in relation to the magnitude of alcohol abuse as a clinical problem and its acknowledged impact on family life. There's little scientific evidence to demonstrate efficacy of family therapy or its value relative to other forms of alcoholism treatment (Steinglass, 1979).

Families of alcoholics are helpful in providing support for the patient and helping him remain in treatment. Family treatment is frequently indicated and may be helpful to prevent problems in spouse or children of alcoholics.

Family's involvement in treatment is different across cases. When the chemical dependence seems to be mainly owing to dysfunctional patterns 'in the family as a unit' or where the chemical dependence has led to dysfunction in the family it will need slightly less intense but active participation by the family in treatment and the focus will be on "family as context". Independent of this model, the importance of involving family members in treatment of drug and alcohol dependence is well substantiated (Desai, 1989; Mane 1989).

Originally, alcoholics were conceptualised as homeless, jobless, physically ravaged individuals with meagre psychological resources, it is now clear that the 'end stage' alcoholic is most unrepresentative of the patient population that abuses alcohol. A significant proportion of the alcoholic population continues to function within nominally intact and stable family systems. Family therapists may not be fully convinced of the need for family therapy techniques, the symptom itself is so pervasive as to be virtually unavoidable. Clinical interest focussed on disturbed communicational patterns and structural dissonance within the family.
Marital Therapy:

As early as 1954, a pioneer project initiated at John Hopkins Hospital involved concurrent group meetings of male alcoholics and their wives (Gliedman, 1956a,b, 1957) and positive outcomes in marital/family interactions were obtained. Following this (Mac Donald, 1958; Burton, 1962; Pixley and Stiefel, 1963; Pattison, 1965; Westfield, 1972) confirmed it. The treatment focus subsequently changed from the alcoholic individual alone to the alcoholic individual in a marital/family interactional context.

Favourable improvements were strongly supported in studies carried out by Ewing and Fox (1968) and Smith (1969). Gallant et al., (1970) conducted multiple-couples group therapy and concluded that marital-couples group therapy is the treatment of choice at this time for married alcoholic patients. Family/marital therapy approaches need more attention, making pertinent differentiation between intensive marital therapy and involvement of the spouse in other treatment methods. O‘Farrell (1992), did research on the effectiveness of couple and family therapy to initiate, stabilize and maintain recovery from alcoholism.

Social Work With Substance Abusers:

As a profession social work has made a longstanding commitment to view problems like those associated with use of alcohol and drugs differently than workers in other helping traditions (Freeman, 1992; Specht and Courtney, 1994).

In the past social workers avoided helping individuals with substance abuse problems (Googins, 1984). So social workers are not viewed as professionals with expertise in working with individuals who abuse drugs. In fact many social workers
indicate that they do not work with substance abusers when ironically many of the people they serve are using or abusing substances. Because most individuals who abuse drugs have myriad problems in living, social workers are often the first human services professionals they meet when they enter various service delivery systems. It is at this juncture that social workers need the expertise to develop appropriate programmes and interventions for directly addressing drug abuse as a major problem (Gray, 1995).

In late 1980's in US leaders in large urban areas developed community coalitions to address substance abuse problems. This coalition assessed problems, reached out to various groups, developed comprehensive plans and mobilised public opinion through media campaigns (Falco, 1992). Communities need assistance in community organising, grassroots organising and lobbying areas in which social workers have knowledge and skills.

However, recognising the difficulty in working with substance abusers different approaches are still being addressed. The generalist social work practice is another approach for families affected by substance abuse. This is concerned with both individual troubles and the social problems that contribute to these troubles (Landon, 1995; Pinderhughes, 1995; Schatz, Jenkins and Sheafor, 1990).

Family support programmes are at the front line of community-based services for families and thus deserve careful attention from social work profession. Effective family support programmes challenge and reformulate mainstream person-oriented agency based social work practice. Good family support programmes demonstrate in fact the sort of holistic, contextual and empowering practice that brings to life social works 'new-old' concern with the person in his or her environmental context and
revitalises the profession’s historic commitment to serving families. Family support programmes thus reflect a preventive, non-deficit approach focused on the provision of normalised services and the enhancement of resources and competence rather than dysfunction and treatment (Lightburn and Kemp, 1994).

Congruence model is a theory based family counselling/education approach (Friedemann and Youngblood, 1992). This approach is able to focus on family strengths and break recurring patterns of behaviour in an effort to establish new goals and aspirations. It is a client directed intervention that focuses on coping and problem solving for couples. This approach de-emphasizes the alcohol problems and let clients determine their own goals depending on the needs of the family. Interventions strengthen the functional strategies through learning new strategies to deal with problems through discussions, role-play and practice of behaviour sessions.

In treatment the emphasis has always been on the abstinence model. Reducing harm caused by alcohol and drug use, rather than on the use itself is consistent with social works holistic meet-the-client-where-he/she-is-approach. Under harm reduction approach social work intervention would be geared towards community prevention work and early treatment of drug users to monitor their use and lifestyles (van Wormer et al., 2000).

Parenting groups for recovering drug addicts in a day treatment centre using brief dynamic group therapy is another approach that is being tried (Plasse, 1995). Family preservation services for children are intended to remove the risk of harm to children in their homes, instead of removing the child from the home. They combine with chemical dependency treatment. These programmes have structured for safety by mobilising non-using social network resources; incorporating relapse prevention
intervention techniques as part of skill building and motivating family members to seek, enter, and complete treatment (Blythe et al., 1991; Tracy, 1995).

Besides there are prevention programmes in school, no-use policies abolishing use of any drugs including alcohol. Anti-drug preventive programmes focussed on personality issues and self-esteem (Saunders, 1995).

With regard to family interventions in the Indian setting Desai (1993, 1994) applied the framework of family-centred social work practice. A framework of assessment of individual families was developed to understand their problems in the context of socialisation of family norms, family ecology and family dynamics. The area of intervention was also delineated. The different types of family interventions are family advocacy, family counselling, family therapy, crisis intervention (Shah, 1994), self-help groups (Veedon, 1994), legal aid, family rehabilitation (Kashyap, 1994), training of paraprofessionals, monitoring and evaluations of family intervention (Desai, 1994), interventions with rural families (Verma, 1994), families of alcoholics and intervention (Chitale, 1994), abuse and violence in families and interventions (Rane, 1994; Dave, 1994).

Utilisation of cultural elements in the treatment of alcoholism in the Indian social fabric has always given a great deal of weightage to components like social control, relating to elders with reverence as resources for counselling and direction. Some of the innovative approaches have been able to use these components effectively. Techniques of social control like conscientisation, networking, pressure, group building, awareness, campaigns training and political intervention. The interventions have not only been at treatment level but have integrated prevention and rehabilitation (Chitale, 1994).
Religion-based approaches have been common in India as reported by Chitale (1994). Some of these approaches are 'Varkari Sampraday' and 'Jeevan Vidya' group. The effectiveness however has been short lived if no therapies are offered. The strategy these groups use is a group norm of abstinence. Tension and stress release methods are also provided through techniques like meditation, prayer and sublimation. Yoga techniques have been used for stress management and in the field of alcoholism.

A new approach towards treating alcoholics in a rural population was the 'camp approach'. The first camp was held in 1989. Favourable outcomes have been achieved and are identified due to several factors (Ranganathan, 1994).

The rehabilitation model of management in alcohol and drug abuse needs to be further strengthened. The treatment target is not only removal of desire for alcohol but it also includes restoration of the person to reasonable adaptation equilibrium (Gandevia, 1989).

Focusing on the role of social workers as advocates necessitates an interest in public substance abuse policy. To respond appropriately, they must acquire more knowledge about substance abuse policies and programmes. They should support policies that increase public understanding of origin of substance abuse problems and effectiveness of prevention and treatment programmes (Saunders, 1995).

Social workers have a role to build alliances with personnel in agencies that deal with substance abuse, especially in the criminal justice system to promote more humane policies. The reduction of substance abuse problems should not be viewed as a moral crusade. The main priority should be to adopt policies that reduce harm caused by alcohol and drugs, to eliminate policies that stress punishment to deter
Such policies should emphasise the promotion and protection of health and prevention of disease. National Association of Social Workers (1994) has a policy statement on alcohol and other drugs that serve as foundation for advocacy efforts.

The field of alcoholism is an important subject for students of social work in India, as social work practitioner comes across the problem in any type of field setting and practice be it health, children, family, law and advocacy, women correction or community settings.

A recent study (Alaszewski and Harrison, 1992) found that social workers have little exposure to specialised course work or curriculum content about substance abuse issues and remain more focused on abstinence model and the traditional case work approach besides working as team members in different therapeutic settings.

Although social work education has not included enough specialised content on the abuse of alcohol and other drugs (Van Wormer, 1987). Some efforts to integrate information on alcohol and drug abuse throughout Social Work curriculum are under way, as are efforts to increase social work faculty members' interest in substance abuse (Corrigan and Kola, 1993).

Prevention:

The face and substance of drug abuse prevention has changed dramatically in the past decade. Prevention of drug abuse has become an integral part of intervention. Prevention programmes are an acknowledged part of most schools' curricula (Connell, et al., 1985; Johnson, 1986).

Programming is initiated before or during the years associated with gateway drug use onset, usually middle or junior high school, rather than after drug use is prevalent in high school (Connell et al, 1985; Tobler, 1986). Programme content has
changed from what drugs look like and how they are used, to training skills in how to avoid drug use situations (Battjes and Bell, 1985; Tobler 1986).

School programmes have been most common and widely evaluated. Results of research are consistent in showing 20% or larger net reductions in rates of drug use (Botvin, 1986; Tobler, 1986). Most programmes have been aimed at school attending youth. Little has been done on programme effects on school dropouts and students in identified high-risk groups.

Researchers have debated for almost a decade over the question of whether drug prevention programmes should be (i.e. focused entirely and specifically on drug use) or should be more socially generalizable (i.e. focused on a broad range of life skills that include but are not limited to drug use prevention) in order to be most effective (Botvin, 1986).

Reviews of specific and general skills, programme suggests that both are effective if they include pressure resistance and assertiveness skills (Battjes and Bell, 1985; Botvin, 1986; Flay, 1986; Murray et al., 1989; Tobler, 1986).

STRESS

Stress refers to a response of the organism to a noxious or threatening condition. Manifestations of stress are found at every level of organismic functioning from the microbiological to the emotional. Stress can be both a short-run response and a pattern that emerges slowly over time; individuals may be keenly aware that they are host to stress, although stress may also be present at a level below consciousness, stress responses can be highly contained and situationally bounded, but they can also develop into a prevailing state that persists through time and
extends through space. It is thus a multidimensional, interconnected phenomenon. Several classical studies viewed society and culture as a reservoir of personal stress and maladjustment (Myrdal, 1944). The other approach that influenced a lot is ‘Social Structure and Anomie’ (Merton, 1957). Marris (1974) pointed out that social change leaves people with a sense of loss of control over their own destinies. People's location in stratified economies has stressful consequences. Psychological distress increases linearly with a decrease in income level (Jackson, 1967; Pearlin and Radabough, 1976; Hornung, 1977, 1978).

Institutionalised aspects of family life results in stress, a focus that is quite different from that which centres on the individual experiences of family members. The family has multiple functions in the stress process. The problems encountered elsewhere can be expressed within the family. It can be a target for displaced stress. It is also a source of solace and sympathy when people suffer defeat in the outside world. Several institutional and structural features of the contemporary family help make it a potential source of stress, as well as a source of succour.

Life Stress and Health:

The study of effects of social conditions on the diffusion of distress and disease in the population can be traced to Durkheim’s study of suicide in 1897 (1951). The associations between the various forms of social integration and psychiatric disorder have been elucidated through Faris and Dunham, (1939), Hollingshead and Redlich, (1958), Langner and Michael, (1963) and Srole, (1975). Selye, (1956) elucidated the general adaptation syndrome, where mild stressful events occur in close succession their effects on bodily resistance and disease can be cumulative and serious.
Life Events – The Social Stressors:

Holmes and Rahe (1967), accepted Selye's (1956) notion that life stress is the physical or psychological change elicited in response to an event, independent of the desirability of the event, and is quantifiable in terms of either the number of events experienced using the Schedule of Recent Experience (SRE) or the additive total of the changes required by all events using the Social Readjustment Rating Scale (SRRS: Holmes and Rahe, 1967; Rahe, 1978). Numerous other instruments along with Holmes and Rahe were developed in the 1970's and more than 1000 publications appeared on SRRS alone with various samples. Few studies have criticized life events research and negative findings have also occurred (Gersten et al., 1977).

Finkel, (1975), Chiriboga and Dean, (1978) have reported the finding that some degrees of stress are growth promoting and positive is now becoming widely accepted. An alternative construct for life events stress emphasizes the psychological and emotional aspects of the response to events and differentiates events in terms of the degree of undesirability (Paykel, 1971) or threat (Brown and Harris, 1973) individuals' degree of anticipation or control over them. Thus, until the stress construct is defined with more clarity (eg. in behavioural, social as well as physiological terms) little progress will be made in understanding the specific risks entailed by the experience of life events.

Life Stress Paradigms:

Stress has been found to be associated with physical health. Dohrenwend and Dohrenwend (1981) summarized various formulations of life stress processes and the psychological and social contexts in which they occurred by delineating several
models. Psychological stress/strain in contrast to psychological resources increases or exacerbates health problems. It has commonly been referred to as psychological vulnerability, which may lead to the onset of an actual physical illness (Mellinger et al., 1978). Various indicators tapping psychological stress as well as strains (Pearlin et al., 1981) have been employed. In general the research shows that life stress exerts a significant but moderate influence on mental and physical well-being.

Stress and demographic background have been extensively associated (Horowitz et al., 1979; Dohrenwend et al., 1978). Stress is defined in relation to both the person and the environment (Lazarus and Launier, 1978; Holroyd, 1979; Coyne and Lazarus, 1980).

The Stress of Caring:

A special focus is given on the stress of caring by women, as they are primary caregivers in families. Study of women's experience of stress is very rare. Most studies have researched male populations.

Wilkins (1974) pointed out that there is a 'contagion of stress' from husband to wife and relatives. Contemporary theories of women's psychology (Chodorow, 1974; Miller, 1976; Gilligan, 1977) emphasize women's embeddedness in social relationships.

Women in their family roles as providers of social support to children, husbands and other kin often give more support than they receive. Women it is said provide more protection to men in marriage because more support flows from women to men than vice versa.

The combination of work and family responsibilities results in stressful workload for many women (Maracek and Ballon, 1981). Whether employed or not,
women who rear young children with low incomes are at high risk for depression (Brown et al., 1975; Radloff, 1975; Pearlin and Johnson, 1977).

**Life Events Research:**

Life-events research relating to addiction is a rather less well-explored area. In the specific area of addiction, examination of the data from a number of studies suggests that there might be a relationship between life events and the course of addiction to alcohol, heroin and smoking (Saunders and Kershaw, 1979; Stimson et al., 1982). Tuckfeld (1981) has made a distinction between those events producing change and those serve to maintain any such change, a useful conceptual distinction.

However, overall the picture is confused and frequently contradictory, and little has emerged by way of a coherent and replicable account of the role that life events play in the course of the addiction process. Life events (LEs) and addiction research studies reviewed can be divided into two categories. Primarily, those that show an increase in consumption, or relapse amongst drinkers and drug addicts after life change. These categories are further subdivided into (i) the effects of LEs on treatment outcome and (ii) studies of the incidence of LEs in the lives of drug users and drinkers. Secondly, those that show a decrease in or remission from, use of addictive substances after life change. These categories are further subdivided as described for the primary category.

Studies showing either higher consumption or relapse, after life change and the effects of life events on treatment outcome of alcohol has been reported by Rosenberg (1983); Moos et al., (1979); Marlatt and Gordon's (1980) and Krueger (1981). Studies of incidence of life events in the lives of drug users and alcohol users
has been reported by Dudley et al., (1976); Tattossion et al., (1983); Reinecker and Zauner, (1983); Fowler et al., (1980).

Studies showing decrease in, or remission from addictive behaviour with effects of life events on treatment outcome reveals no studies with alcohol, opiate or smoking treatment programmes.

Studies showing incidence of LEs in the lives of remitters – alcohol has been examined by Smart (1976); Saunders and Kershaw (1979); Tuckfeld (1981); Stimson and Oppenheimer's (1982).

It appears from these contradictory studies that simply counting, or trying to measure the impact of individual events cannot assess the influence of LE's. A theory that takes account of these opposite results must look at the interaction between trait characteristics of the person, events, and the state of the individual at the time of occurrence (O'Doherty and Davies, 1987). Thus, there is sufficient consistency to suggest that there might be something in the life events data but it is difficult to pinpoint what, or how and no strong model has emerged.

Cole et al., (1991) found that alcoholics might offset stress induced emotional distress by resorting to drink which in turn might lead to a further increase in negative life events. Life events (stress) indicate that the difference between alcoholics and non-alcoholics is significant. Alcoholics experience more life change events (stress) when compared to normal (Thankachan and Kothandaram, 1993; Mathew and Baby, 1998).

Moving from individual life stress to family stress reactions, heightened anxiety and insecurity and other 'personality changes' are also noted among the reactions of family members to crises or stressful circumstances. 'Disturbance' in the
non-alcoholic spouses Orford observed (1976) can be partly attributed to non-specific stress or crisis factors. The relationship between individual and family stress needs an enumeration on the historical developments, conceptual frameworks and research applications.

Family Stress:

Family stress as one of the areas of research stemmed from the decade review of conceptual frameworks in family crises research of Broderrick (1970). This family stress research may be traced to Burgess (1926), Angell (1936), Cavan and Ranck (1938), Koos (1946) and particularly to Hill's (1949) classical research of 'ABCX roller coaster course of adjustment'. This has remained virtually unchanged for over thirty years. Since 1970, investigators have carried on family research in an effort to render clarity and empirical support to the original conceptualisation (Mc Cubbin et al., 1980).

In 1973, Burr synthesized ABCX formulation into a bonafide part of deductive theory and added 'vulnerability and regenerative power' to Hills formulation. Based on this, stressors are defined as those life events or occurrences of sufficient magnitude to bring about change in the family system. Stress was conceptualised as a function of the response of the distressed family to the stressor and refers to the residue of tensions generated by the stressor that remains unchanged. Crisis thus refers to the amount of incapacitatedness or disorganization in the family where resources are inadequate (Burr, 1973).

Lipman-Blumen (1975) advanced one of the most comprehensive schemes for the assessment of family crises. Mc Cubbin, Wilson and Patterson (1979) later applied the Holmes and Rahe (1967) procedures to obtain standardized weights
(assigned by family members) for family life events as indices of family hardships. Based on the conceptual formulations, predictably family stress research has followed a course of examining the impact of social problems and focusing upon those life events and hardships that were of prominence and social concern. Later, many investigators turned their attention from short-term acute stressors to the study of family behaviour in response to long-term chronic stressor events (Meon, 1979) including that of alcohol and drug abuse.

The family that already struggles with other life changes such as developmental transition and related role changes has a bearing on the expressive and instrumental resources to cope with the additional long term chronic stressor event like substance abuse.

COPING

Coping refers to efforts to manage environmental and internal demands and conflicts among demands (Lazarus, 1966, 1981). This definition focuses explicitly on efforts to manage, that is, on the dynamic constellation of thoughts and acts that constitute the coping process. The emphases on what people are actually thinking and doing during a stressful encounter contrasts with the more dominant approach to understanding individual differences in response to stress or historical events in the individuals life, say death of parent during childhood (Brown and Harris, 1978), on personality traits (Kobasa et al., 1979), motive patterns (McClelland, 1979; McClelland et al., 1980). Thus, it goes a step further in understanding stress.

The theoretical antecedents of coping concepts showed four related perspectives enlightening the search for formulations and measures of coping
resources and processes. They are psychoanalytic theory, life cycle theory, evolutionary theory and behaviour modification and cultural and social ecological approaches.

The four elements identified by the four perspectives are integrated in a framework that conceptualises the link between life stress and functioning as mediated both by personal and environmental coping resources and by cognitive appraisal and coping processes as well as their interrelationships.

The general coping resources are self-esteem, ego-identity, competence motivation, novelty needs and stimulus seeking behaviour (Moos, 1974). Coping resources, such as self-efficacy, internal control, sense of mastery, and ego maturity have received the most attention. These resources can affect the appraisal of potentially stressful situations, anticipate and avoid stresses as well as selection of coping responses to handle such situations.

Although several attempts have been made to classify appraisal and coping responses (Moos, 1976, 1977; Haan, 1977; Lazarus and Launier, 1978; Pearlin and Schooler, 1978) no accepted method has emerged.

The dimensions of appraisal and coping are categorized into three domains according to their primary focus. Appraisal – focused coping involves attempts to define the meaning of a situation and includes strategies as logical analysis and cognitive redefinition.

Problem – focused coping seeks to modify or eliminate the source of stress (destroying an alcoholic husband's liquor supply) to deal with the tangible consequences of a problem (taking over family responsibilities when the head of
household is ill), or actively to change the self and develop a more satisfying situation (learning new skills and enhancing independence).

Emotion-focused coping includes responses whose primary function is to manage the emotions aroused by stressors and thereby maintain effective equilibrium. These categories however are not mutually exclusive.

Coping leads to adaptation and health outcomes are a product of effective coping rather than simply a consequence of the presence or absence of stress (Henry and Stephens, 1977; Antonovsky, 1979; Roskies and Lazarus, 1980).

Coping can influence health outcomes and comes into being when illness behaviour (i.e. reporting symptoms/and or seeking treatment) or actual physiological symptoms serve coping functions. Illness behaviour may serve stabilizing functions in conflicted families (Minuchin, et al., 1978) or be maintained by secondary gains or reinforcements (Whitehead et al., 1979).

Coping may contribute to disease because it involves changes in health behaviours that expose the individual to injurious agents such as alcohol, tobacco, smoke or allergens. Finally, the way the individual copes with the demands of chronic illness (Cohen and Lazarus, 1979; Shontz, 1982) or the threat of acute illness (Moos, 1982) can be an important determinant of the course of illness and medical care received.

Psychological Resources:

Coping resources have been used to explain differential vulnerability of individuals to illness, controlling for the level of stressors they experience. While social support can be characterized as an external form of coping resources, internal or psychological coping resources have come to play a major role in the aetiology of
both mental and physical health (Folkman and Lazarus, 1980; Kobasa, et al., 1981; Everly et al., 1981; Pearlin et al., 1981; Wheaton, 1983; Gore, 1985). These resources are hypothesized to affect the ability and effort of individuals to recognize the stressful social stimuli (i.e. life events) and trigger a response reaction to the stimuli in an attempt to prevent or eliminate potential distress.

Effective Coping:

There is popular interest in psychological interventions designed to reduce the psychological and somatic costs of stress by facilitating effective coping (Meichenbaum and Jeremko, 1972; Everly et al., 1981). Biofeedback and cognitive behaviour therapy are two popular approaches to stress management. This gives an opportunity to examine the fundamental relationship between coping and adaptation.

Moving from general coping to coping with alcoholism the family responses to excessive drinking are presented below from different studies. Before 1950, scattered reports concerning family factors in alcoholism appeared. The first concerted effort in this direction was a series of clinical reports about marriages between male alcoholics and their wives (Bailey, 1961).

The primary concern centred on the role of the wife in initiating and perpetuating her husband's drinking (Bergler, 1949; Futterman, 1953).

One of the early studies on family coping was by Jackson (1954) whose 'stress model' pointed out that a progressively worsening family situation offered no clear guidelines for coping behaviour. Wives were forced to evolve techniques of adjustment by a process of trial and error. The family also affects the alcoholic and
his illness. The family can either help or interfere with the treatment process (Jackson, 1958).

James and Goldman (1971), said wives tended to report progressive increase in all types of coping behaviour depending on the intensity and frequency of alcohol episodes. This also belongs to the stress reaction tradition.

Orford et al., (1976) opined that personality might play a strong role in determining coping behaviour. They reported that high frequency of coping behaviour was associated with poor outcome in alcoholics. Orford found a strong association between various coping behaviours and alcoholic symptoms, hardship, job status, wife’s age and neuroticism score.

Based upon the qualities of parenting and the characteristics of the families from which the young people come (Blechman, 1982) professionals have often held the families responsible for the drug taking problems of one member (Paolino and McCrady, 1977; Cermak, 1986).

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). Social isolation is part of the family reaction particularly when shame is part of the family reaction (Orford, 1976).

Wives had been separated from their husbands at least for some time in their married life. It is one of the tactics used by the wives of alcoholics. Bagadia et al., (1981) also corroborated similar findings where very few divorces were noted.
Coping within the couple has been explained with the help of two case studies. Based on lengthy open-ended interviews and family meetings a typology of actions for coping has been drawn up for a drinking, drug or gambling problem in the family. The types of coping identified are emotional, tolerant, inactive, avoiding, controlling, confronting and supporting.

Holmiča (1988), in her research with young, married Finnish couples supported the above coping mechanisms. She found a great deal more control of husbands drinking by wives than vice versa, and she has developed the view that it is a normal part of a wife's role to control her husband's drinking in the ordinary course of family life.

In Orford's study (1992), wives, parents, sisters and other relatives talk about the lack of support they get in the coping efforts. There are several reasons as shown in the quotes below: 'we don't get on', 'our relationship is tense', 'I am ashamed to tell them' and alike. The forces in the extended family that could be used for change have been neutralized by these various factors. The family lacks a united front, a cohesive plan for coping, or family policy. The social world external to the family is also populated both by agents who support family members in their coping actions and others who do not support some family members' coping actions. Heavy drinking friends and work colleagues and tolerant landlords are often seen, not just as people who fail to provide support for a wife or other relatives in her coping actions, but also as part of the problem itself. People who share the same excessive drinking habits are particularly likely to be tolerant, so also the suppliers.

In the Indian context, wife beating is also a cause for further breakdown of marital relationships. Since divorce is not encouraged in India, the amount of
suffering the spouses underwent with their alcoholic husbands is enormous. Indian wives are brought up to believe in the total sanctity of marriage, which symbolises a sacred relationship and which should never be broken. 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, 1983).

High levels of conflict have frequently been noted in other studies (Bullock and Mudd, 1959; Gorad, 1971). The various sources of hardship include loss of family earnings, infidelity, and involvement with police rowing and physical violence (Jackson, 1963; Haberman, 1965).

In a collaborative multi-centred study in UK the objective was to interview 50 close relatives of identified problem drug users in clinics and self-help groups. Except for Dorn et al.'s book (1987) no research has been conducted which examined the impact on the family of having a problem drug user as a member in particular, the nature of relatives' coping, support, and the other social-psychological issues in having a problem drug-user in the family.

The investigators contended that the rarity of this type of research is a reflection of the kinds of attitudes that exist towards relatives because professionals have usually failed to take an interest in these relatives. One drawback of this type of research was the absence of any control or comparison group.

Relatives' Reaction:

Velleman (1992) describe the families of alcohol abusers and problem drug users. The study outlines a series of qualitative information on the relatives' reaction as reported in this section. 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.

Many family members provided accounts of their drug-using relative phrased in quite negative terms. They described negative attributes, which the drug-user possessed such as jealousy, aggression, blaming or accusing or ‘couldn’t care less’ attitudes, stubbornness, difficult demanding manipulative or secretive manner, or deviousness. Many talked about their sense of hurt, their reduction in involvement or affection for the user, their embarrassment by, or bitterness towards the user, or their feelings that they had been badly let down by him or her. On the other hand, and perhaps less expected, was the fact that many were also able to describe their relative in quite positive terms, with family members giving accounts of their relative’s gentleness, consideration, caring, sensitivity, and so on.

The set of experiences points to a variety of negative effects on the family member. Many relatives described a wide range of short-term negative experiences such as feeling lonely, isolated, tired, drained, unsupported, anxious, depressed, suicidal, guilty, tearful, apprehensive, worried, fearful, tense, and confused. Many talked of the effect on their relationship with the drug user, saying that it had changed for the worse, describing rows and arguments, worsening sexual relationships, and a breakdown in trust and communication. Several described practical changes due to the drug user’s behaviour which were negative such as having a more restricted social life, having financial problems, having their work affected, and finding that their roles within the family were changed. Majority of the relatives talked about long-term negative feelings, or major changes in physical or
psychological health, including such physical symptoms as ulcers, raised blood pressure, and psychological ones such as anorexia, depression, panic attacks, and 'nervous breakdown' (Velleman, 1992).

Given the range of negative experiences, yet many relatives gave positive experiences overall, with people talking about their life having improved, or having more meaning now. There was, however, a significant negative correlation between relatives' ability to see positives in their situation, and the degree to which these relatives were near the peak of a crisis in their response to the drug use suggesting that many of the relatives who reported positive outcomes were referring to times where problem drug use had lessened or ceased.

**Familial Effects:**

The study by Velleman (1993) reported unfavourable outcomes for the family as a whole, including routines being affected, family life being restricted, family rituals such as Christmas, birthdays or holidays being affected, and reducing standards of living for the family. Again surprisingly, many respondents were able to tell of positive outcomes for the family as a whole, including the whole family becoming closer, or stronger, or there being increased spirituality; these results were more commonly reported by family members referring to times when the problems associated with the drug use had lessened or ceased.

**Relatives' Coping:**

Relatives' methods of coping showed that the majority described actions, which were angry or withdrawing. This category included a family member being angry, violent, considering or actually leaving and (if user was a partner) reducing
the frequency with which he or she would have sex with the user, or starting a new sexual relationship with someone other than the drug-using partner.

A majority followed strategies, which were described as non-contentious or non-confrontative. This included being tactful, sympathetic, giving in to the user, colluding or cushioning or protecting the user and helping out financially or in other practical ways. Many attempted to be firm in one way or another. These ways included trying to control the drug use, checking up on the user, standing up to the user, teaching him or her a lesson, and asking him or her to leave (Velleman et al., 1993).

Several actions were self-protective. The relative put him or herself first, tried not to care for the user so much, took up other interests, became more absorbed in other activities, and tried to become less enmeshed with the user and his or her life. People talked about 'learning to let go and allow his use of drugs to be her concern'. The respondents described actions, which included being inconsistent, 'living from day to day', or 'living one step at a time', and hiding these problems from others.

Future Hopes:

Finally, respondents expressed their hopes and fears for their futures. Many described a generally negative view, with some being pessimistic, others fatalistic, and others feeling vague, uncertain or ambivalent about the future. Several respondents had also expressed about specific concerns that they had, including a fear that the user would leave, or destroy other family relationships, or a worry that other family members might become involved. There was also a concern about the risk of AIDS. Yet again, however, 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.

A similar theme, which emerged from the interviews, was that of 'suspicions, worries and uncertainties'. Although some have learnt to worry less, nearly all have at some stage found their lives to one degree or another taken over by worry about their drug-using family member. They are worried about where the drug user is, what he or she is doing, whether he or she is getting into further trouble, what the relative him/herself has done wrong in the past and what he or she could do now to put things right, how other members of the family are being affected, what the future holds for the drug user, the relative and other members of the family, and so on (Velleman et al., 1993).

These anxieties are associated with 'altered feelings' towards the drug user. Almost invariably the relatives have expressed highly ambivalent feelings, reporting both strong positive components (love, admiration, care, etc.) and even stronger negative ones (rage, disappointment, wish for separation, etc.) Alongside these heightened feelings there is frequently a sense of uncertainty, worry and suspicion about how to understand or make sense of the problem or about how to act towards the drug user.

The results concerning the problems caused by the drug user's behaviour were very comparable with those emerging from the research into the families of problems drinkers (Velleman, 1992), where certainly the violence, unpredictability and embarrassing behaviour were remarkably similar.

Forty-six wives of alcoholics were administered Orford and Guthrie's Questionnaire and Eysenck's Personality Inventory to study their coping
behaviour. All the individuals used the ten styles of coping behaviour. Discord, fearful withdrawal and avoidance were the styles used most. 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. Another rarely used style was marital breakdown, where the wife rarely asked the husband to leave or be separated from the husband for a few days or sought legal separation (Chakravarthy and Ranganathan, 1985).

A study of adjustment patterns in wives of alcoholics was done on 85 wives of alcoholics in a clinical setting using Bells Adjustment Inventory. Wives as a group tended to manifest an average adjustment in social and occupational spheres. The maladjustment was shown on home, health and emotional areas showing they suffered physically and emotionally. Wives also experienced and manifested certain emotional responses such as feelings of guilt, anger, resentment, hurt, fear, loneliness, helplessness, lack of social and financial securities (Rajendran and Cherian, 1990).

One Indian study (Sathyanarayana Rao and Kuruvilla, 1992) based on a self report by the wives of alcoholics found that discord, avoidance, indulgence and fearful withdrawal were the common coping behaviours and marital breakdown taking special action, assertion and sexual withdrawal were the less used coping behaviours.

Chandrasekaran and Chitralekha (1998) studied one hundred wives of alcoholics with a confirmed diagnosis of alcohol dependence syndrome with a 'coping with drinking questionnaire'. 'Avoidance' was the most commonly
endorsed coping behaviour. There was a significant correlation between all the coping components and alcohol related problems. No correlation was observed between neuroticism scores and coping behaviour.

The methods of coping were related to the personality of the wives and other situational variables. Given the correlational nature one cannot attribute any reference to causality. This is because wife's coping behaviour and husband's drinking behaviour can influence each other significantly. The several Indian studies have focused on the spouse's coping rather than the complete family. This has given a lot of insights into the way the problem is understood culturally.

In times of crisis, distress or problems a supportive person, group or organisation makes a difference to the situation and the person. If life stress is an aspect of social environment social support enhances one's ability to either improve well being or to counter potential adverse effects of life stress. Social support is defined as the process (eg. perception or reception) by which resources in the social structure are brought to bear to meet the functional needs (eg. instrumental and expressive), in routine and crisis situations. It has been argued that intimate relations with others whom one might confide in and receive feedback from may significantly affect one's mental and physical health. Some have argued that such an effect is direct and independent of life events, while others have suggested that social support mediates or buffers the effect of life events on illness. The mediating effect is said to occur when the incorporation of the social support factor reduces the direct effect of life events on physical health or mental health. The buffering (interacting) effect is said to occur only if the simultaneous presence of life events and absence of social support exert a deteriorating effect on physical or mental health.
In general, the independent and mediating effects of social support have received strong confirmation (Barrera and Ainlay, 1983; Leavy, 1983; Wallston and Wallston, 1984; Berkman, 1984,1986; Cohen and Wills, 1985; House and Kahn, 1985; Wethington and Kessler, 1986; Lin, 1986). Likewise a number of studies have provided evidence for buffering effects (Kessler and Mc Leod, 1985; Cohen and Wills, 1985).

Perceived social support (PSS) refers to the impact networks have on the individual. If networks provide support, information and feedback (Caplan, 1974) then perceived social support could be defined as the extent to which an individual believes that his/her needs for support, information and feedback are fulfilled (Procidano, 1983). 'Network' the social dimension of social support constitutes the fourth issue. Studies are concerned with mere existence of network while others consider the characteristics of the people in the support network. These issues are interdependent.

Social network characteristics refer to the social connections provided by the environment and can be assessed in terms of structural and functional dimensions (Marsella and Snyder, 1981). Size, density, multiplexity refer to structural network characteristics. Network functions include the provision of information, comfort, emotional support, material aid etc.

In studying the role of social supports in substance abuse a set of factors help to nurture and sustain the recovery process. These maintenance factors include support from a spouse or partner, extended family, an employer, friends, change in life style and social activities, less tolerance of and growing physical aversion to the

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abused substance and an emerging sense of commitment, accomplishment, and pride (Saunders and Kershaw, 1979; Ludwig, 1985; Sobell et al., 1993).

Previous literature emphasizes acute life events as precursors of change, chronic stressors and ongoing social resources also play an important role in recovery. Life crises may jolt people out of destructive patterns of substance abuse, but it may be difficult to sustain remission in a context ridden with chronic financial, health, or interpersonal stressors. Similarly, a lack of ongoing social resources may hamper sustained recovery.

Having more resources especially social resources makes it more likely that problems associated with alcohol consumption will be pointed out by others and/or recognised by individuals resulting in an increased likelihood of treatment seeking indicating the moderating effect of social resources.

People trying to resolve substance abuse problems usually begin by using one or more sources of informal help such as a family member or friend, physician, Alcoholic Anonymous member or another mutual support group. If such attempts fail repeatedly, some people enter formal treatment. Outside help may be needed when an individual has few personal or social resources on which to base a recovery (Armor and Meshkoff, 1983). In contrast, relatively stable factors in people's lives, such as informal help and ongoing social resources, typically play a more enduring role. Alcoholics experience the disintegration of concomitant supportive social structures through loss of family integration (Rossow, 1993).

The support received by relatives was informal (family, friends, work colleagues, clergymen, etc.), formal (from a professional agency such as a drug advice service, community drugs team, general practitioner, community psychiatry
nurse, psychologist, etc.) and self-help support (most commonly from Families Anonymous). Hence, most family members had some sort of support available to them, and many had more than one form of support. However, although most family members that interviewed had some support many of these relatives were dissatisfied with it, especially with that received from 'formal' agencies. In another study with regard to illicit drugs it was often very obvious to family members that neighbourhoods encouraged the very excess that they as family members were at such pains to try and control. The local drug dealers' influences upon the family user seemed to be diametrically opposed to those of the concerned relative (Velleman, 1993). Social support is not a panacea, and there are still gaps in knowledge and there could be unintended consequences of helping others. However, we see social supports play a significant part in making people's lives more endurable by reducing the impact that the stresses and strains of life entail, facilitating better coping.

FAMILIAL ADAPTATION

While there are indications that alcoholism is in fact, impacting the developmental flow of childhood, an understanding of family interaction patterns of alcoholics remains largely unstudied. A number of reviews summarizing the empirical research on family interaction and family environment have appeared (Jacob and Seilhamer, 1987; Seilhamer and Jacob, 1990; Sher, 1991).

Studies of alcoholic families using the self-report Family Environment Scale (FES) indicated that alcoholic families reported lower levels of family functioning such as cohesion, expressiveness, independence, intellectual - cultural orientation
and active recreational orientation and higher levels of conflict compared with non-alcoholic control families (Sher, 1991).

Much of the family disruption appeared to be related to the ongoing drinking problems in the alcoholics. This was observed as the family environments of recovered alcoholics did not differ significantly from those of the non-alcoholic control families (Moos and Billings, 1982). Recent studies using other self-report measures of family functioning supported this conclusion (Callan and Jackson, 1986; Benson and Heller, 1987).

Jacob and Seilhamer, (1987) and Steinglass et al., (1987) have examined interactions using direct observation methods. Their research supports the notions that (a) alcohol serves variety of adaptive functions in different families (eg. permitting expression of certain behaviours and inhibition of others) (b) behavioural observations of alcoholic families both at home and in the laboratory can differentiate families characterized by continued abstinence, continued drinking and a mixed transitional pattern (phases of alcoholism) and (c) there is great heterogeneity in the interaction patterns among alcoholic families is an important generalization.

All these factors depict the way the family responds to the problem of substance abuse. Until recently, the chief adaptive mechanism recognized by family systems theory has been homeostasis. The concept of homeostasis has been synonymous with the concept of a system.

Hoffman has defined a system as 'any entity the parts of which co vary interdependently with one another and which maintains equilibrium by counteracting a deviation. If some behaviour occurs that constitutes a dangerous
deviation from a norm it is counteracted by another behaviour that tends to return things to that norm. This is an important feature of homeostasis. This concept was challenged as being too limited to explain family functioning. Family theorists began to talk about the importance of variety and variability and 'change promoting' processes (morphogenesis) within the family to account for the ability of families to adapt, to change and grow in response to changing circumstances.

These were phenomena that the concept of family homeostasis (morphostasis) was not adequate to deal with. So the concept of positive feedback was added to the family field. In sequence involving positive feedback, deviations from an initial position are amplified rather than counteracted. The value of positive feedback supposedly is that it enables living systems to adapt to changing environments through random deviation selectively amplified by natural events. Positive feedback is thus proposed as a mechanism by which new behaviours are reinforced that would potentially be used in adapting to changing circumstances.

Behavioural patterns in families are described and explained in terms of complex interactions between positive and negative feedback loops. The positive feedback loops create the potential for change while negative feedback loops serve to maintain the status quo. From the developmental point of view they observe that something is lacking even in this explanation.

Beavers and Olson's model is said to rely on the morphogenesis - morphostasis conceptualisation of adaptation. It does not account for the ability of families to change while simultaneously maintaining continuity; mechanisms of permanence (morphostasis) and change (morphogenesis) are treated as operating
singly or sequentially. At this lower level of organisation, mechanisms of permanence and change are split and in opposition, at a higher level of organisation they are integrated so that change can occur while identity is preserved.

Piaget's (1966) notion of 'regulations' is used to supplement the description of this lower level of adapting. In addition, Piaget's notion of 'operations' is used to describe a higher level of adaptive process in which permanence and change are integrated. Because adaptive functioning is tied to degree of organization, one must increase the degree of organization of a family to raise its adaptive level.

Very few attempts have been made to systematically assess the social climates of families. Pless and Satterwhite (1973) developed a semi-structured interview to assess the overall adequacy of family functioning along five dimensions.

Deykin (1972) has recently presented a technique that provides for the quantification of six major areas of family – life functioning: decision-making, marital interaction, child rearing, emotional gratification, perception of and response to community. Deykin found that family-functioning scores were significantly related both to the type of anti-social behaviours seen in delinquent children and to the degree of behaviour change after treatment.

These considerations led to the development of a Family Environment Scale (FES) by Moos and Moos (1976) which assesses the social environments of families along the salient dimensions. It focuses on the measurement and description of the interpersonal relationships among family members, on the directions of personal growth emphasized within the family, and on the basic organizational structure of the family. The FES significantly discriminates among families, is sensitive to parent child differences in the way in which families are perceived, is related to family size
and drinking patterns, and discriminates between psychiatrically disturbed and matched 'normal' families.

The Circumplex Model of marital and family systems based on the systems theory was developed to bridge the gap that exists between research, theory and practice. One major approach used to bridge this gap has been the systematic development of both a self-report and clinical rating scale based on the Circumplex Model.

A variety of hypotheses have been developed and tested using the Circumplex Model. Some research has attempted to look at the relationship between family symptoms and types of family systems. Some of the recent studies are investigating changes in family types before and after treatment and also during the process of therapeutic intervention. Over 300 current research projects focus on a variety of theoretical and clinical issues related to the model.

In addition to research, the Circumplex Model can be used in clinical practice. It can be used for assessing marital and family systems and for planning treatment intervention. The salience of these three dimensions is clearly seen by the fact that other theoretical models in the family field have relied on concepts related to the three dimensions of cohesion, change (adaptability) and communication.

In a recent review of family system concepts L'Abate (1985) concluded that several theoretical approaches used concepts related to cohesion and change. L'Abate (1985) describes the similarity of his concept of intimacy with cohesion, and power with that of adaptability. Beavers and Voeller, (1983) describe centripetal and centrifugal family forces that are conceptually, closely related to cohesion. They use the term adaptability although their operational definition is somewhat different. The
McMaster Model of Family Functioning by Epstein and colleagues (1978) uses concepts that fit well into the three major dimensions. Gottman, (1979) utilized the concepts of validation and contrasting that are closely related to cohesion and change. Kantor and Lehr's (1975) concept of affect is very related to cohesion, and their concept of power is similar to adaptability.

Leff and Vaughn's (1985) concept of distance relates closely to cohesion and problem solving to adaptability. Reiss's (1981) intensive experimental studies rely heavily on a paradigm focusing on family problem solving. His dimension of coordination is conceptually similar to cohesion, and closure similar to concept of change.

While there are three central dimensions in the Circumplex Model, cohesion and change (adaptability) are the two dimensions graphically used in the model. Communication is a facilitating dimension in that it facilitates movement of families on cohesion and change. Studies using the FACES have been done among substance dependent families. Olson and Killorin (1984), found significant differences between the chemically dependent families and the non-dependent families. As hypothesized, alcoholic families had a significantly higher level of extreme families compared to the non-dependent family.

Twenty-one percent of the chemically dependent families were extreme types, while only four percent of non-dependent families were extreme types. About two-thirds (65%), of non-dependent families were balanced, while about one-third (38% and 32%) of the dependent families were balanced.

Bonk (1984), studied alcoholics in treatment both pre and post and follow up after one month. No change occurred over time on cohesion and adaptability. In
summary, these studies of clinical samples clearly demonstrated the discriminate power of FACES and Circumplex Model in distinguishing between problem families and non-symptomatic families. There is strong empirical support for the hypothesis that balanced types of families is more functional than extreme family types.

In contrast to the curvilinear relationship found on these dimensions of problem families, there appeared to be a linear relationship between cohesion and change (adaptability) in family functioning with 'normal' families. Higher levels of cohesion and change seem to be associated with better family functioning. These results were found in the national survey with 1,000 families across the life cycle that was reported by Olson and colleagues in their book titled 'Families: What Makes Them Work'.

A major reason for this finding is that normal families represent only a narrow spectrum of the range of behaviour on these dimensions. Hence, very few of 'normal' families legitimately fall into extreme types. The curvilinear relationship – too little or too much cohesion or adaptability is seen as dysfunctional to the family system. However, families able to balance between these two extremes seem to function more adequately.

In attempting to distinguish among various family types and levels of family functioning many studies have attempted to evaluate the curvilinear hypothesis. The studies observed the degree to which families with balanced FACES scores functioned more adequately than families that achieved more extreme scores on one of the FACES instruments.

Results have been inconsistent with one group of studies providing support for the curvilinear hypothesis. These studies compared families with identifiable
problems to non-problem families. Families of sex offenders (Carnes, 1989), and families with schizophrenic and neurotic members (Clark, 1984) alcoholic (Olson and Killorin, 1984) and juvenile delinquents (Roderick et al., 1986) were all studied.

A second group of Circumplex study report findings using FACES III indicates no relationship between adaptability and cohesion scores and indicators of family functioning. Green et al., (1985), found that balanced families of adolescent probationers were no more likely than mid-range or extreme families to have high scores on measures of individual and family well-being. Walker et al., (1988), found that FACES II would not discriminate families of adolescents with a functional illness from families of healthy adolescents.

FACES II (Olson et al., 1982) and the Clinical Rating Scale for the Circumplex Model (Olson and Killorin, 1985) was administered to 96 adolescent drug abuse clients and their parents in treatment (Friedman et al., 1987). The majority of these families categorized themselves as ‘disengaged’ (rather than ‘enmeshed’) on the cohesion dimension and as ‘rigid’ (rather than ‘chaotic’) on the adaptability dimension. These findings were unexpected, as they were substantially different from findings on families with other types of problems.

Family therapists utilizing Olson's Clinical Rating Scale for the Circumplex Model characterized significantly more of these same families as ‘enmeshed’ rather than ‘disengaged’.

The concepts of ‘disengagement’ (a lack of subsystem connection) and ‘enmeshment’ (a lack of subsystem differentiation), represent symptoms of family pathology or dysfunction and may be expected to apply to families of adolescent drug abusers as well as to families with other types of problems. The finding of lack
of 'closeness' (Kandel, 1974) and the finding of 'low perceived parental support' (Cooper and Olson, 1977), in families of adolescent drug abusers could suggest a low degree of cohesion and of emotional bonding in these families.

The clinical observations in the literature about these families suggest that there is a lack of clear intergenerational boundaries, and that some of the families tend to be excessively cohesive or enmeshed. Findings from Brook et al.'s (1978), study, supports the above clinical observations and also to be consistent with the curvilinear concept of the Olson Circumplex Model. Those families in which there is a greater degree of parental control, a high premium on achieving, high expectation and structured, shared parent/child activity there is a lower likelihood of substance abuse. If any of these attitudes are overdone, then the converse is true. These parental over-concerned attitudes and excessive but ineffective demands may then lead to, or perpetuate substance abuse.

Male heroin addicts were reportedly over involved with their mothers (Chein et al., 1974; Mason, 1958; Vaillant, 1966). Noone and Reddig (1976) reported that while drug abusers and addicts have 'mock separations' from their families of origin, the majority maintained close ties.

Stanton et al. (1978), found that 66 percent of a sample of male heroin addicts who were 28 years of age on the average either lived with their parents or saw their mothers daily. All of these subjects were veterans and had previously been separated from home and in the military service for at least several months. Stanton concluded from a review of literature that there is evidence that a majority of drug addicts maintain close family ties up to age 30 and in many cases, beyond.
The prototypic drug abuser family is one in which one parent is intensely involved with the abuser, while the other is more punitive, distant and/or absent. The abusing offspring serves a function for the parents as a channel for their communication. Consequently, the onset of adolescence with its threat of losing the adolescent to outsiders, elicits parental panic.

The initiation of drug abuse behaviour during the adolescence of the future heroin addict is seen 'as related to an intense fear of separation experienced by the parents in response to the addicts' beginning attempts at individuation'. The drug abuse behaviour permits the addict 'to simultaneously be both close and distant, 'in' and 'out' competent and incompetent relative to his family of origin. This is pseudo-individuation.

A more than average fear or resistance on the part of the parents regarding the separation of the adolescent from the family will be associated with a tendency to maintain a close connection and possibly a type of enmeshment, and that such families would be considered basically enmeshed, rather than disengaged, in spite of the adolescents 'in' and 'out' pattern, because his efforts to individuate are unsuccessful.

In a study of mothers of heroin addicts, Kaufman and Kaufman (1979), found through observations of videotaped family sessions that 88% of the mothers were 'enmeshed' with the addict patient and only 3% were classified as 'disengaged'.

Of the fathers, 43% were 'disengaged' and 41% 'enmeshed' in their relationships with heroin-addict offspring.

Ethnic differences complicated the findings 'in the majority of Italian and Jewish families . . . . the entire family including the father was quite enmeshed.'
Puerto Rican and Protestant fathers were quite disengaged. Other conclusions from Kaufman's 1979 study are not inconsistent with those from other studies of family patterns of heroin addicts (Noone and Reddig, 1976; Stanton et al., 1978; Stanton and Todd, 1982).

The addict provides a displaced battlefield so that implicit and explicit parental strife can continue to be denied . . . . The addict forms cross-generational alliances, which separate parents from each other . . . . Generational boundaries are diffuse; there is frequent competition between parents. Frequently, the crisis created by the drug-dependent member is the only way the family gets together and attempts some problem solving or is the only opportunity for a 'dead' family to experience emotions. In characterizing the family as a whole the descriptions do not appear to suggest a family that is very cohesive, but one that is split by dyadic alliances, a family that has not succeeded in developing a triadic family image, that is, both parents in a unified position in relation to the adolescent offspring.

Fishman et al., (1982) recommended that in conducting therapy with adolescent drug abuse families 'importance is attached to getting parents to work together, reinforcing the family's generational hierarchy. . . . to achieve an intact, in-the-home hierarchy that remains in place at the end of therapy'. Such recommendations suggest that the families before treatment are not cohesive and are not working together well as a unit.

To conclude alcohol and drugs by virtue of pervasive influences has been the subject of research in the field of mental health and social work. Conceptualisation of substance abuse has varied between viewing excessive use as a moral problem in the early stages and later as a disease entity.
Assessing the magnitude of the problem, epidemiological reports showed that substance abuse was prevalent in varying degrees across the country. In searching for the aetiology no single answer is appropriate instead a multi-faceted aetiology is what is accepted currently. The consequences of substance abuse result in serious physical, social and psychological problems to the individual and the family. The aetiology and the consequences reveal a paradigm shift from the individual orientation to the family functioning. The current scenario views family as a supportive institution with inbuilt strengths. There is a need to utilise this resource in the treatment process. While subscribing to such a school of thought, Social Work as a helping profession addresses the need of families and facilitates empowerment for self-reliance.

The attention given to the families of substance abusers has been recent yet it acknowledges the impact on family life. There is little scientific evidence to demonstrate the impact and the adaptation the family makes. Various studies on the stressors to the substance abuse condition indicate the number of life events experienced by the substance abusers. It appears from these contradictory studies that simply counting or trying to measure the impact of individual events do not lead to conclusive results. The stress experienced by the family needs to be comprehensively assessed. Impact of such stressors need to be conceptualised as changes to be brought out in the family functioning. The studies on coping enlighten the need for measures of family coping as compared to individual coping.

All these factors depict the way the family responds to the problem of substance abuse but do not interrelate with the family adaptability in different lifecycles. The literature with regard to general family adaptability and other
psychosocial issues suggests that these families are not very flexible or adaptable to changing needs and conditions. They might be found at one of the two extreme ends of the continuum of being 'rigid' or 'chaotic' leading to unbalanced family types. There appears to be little in the literature, however, to suggest which of these two extremes of the adaptability dimension would be more characteristic of the families with substance abuse especially in a developing country like India.

The emerging trend in the field of social work practice suggests that the strengths based approach to case management with client groups and the emergence of strengths orientations in work with communities. More recently the profession has developed strengths based practice for people with addictions (Miller and Berg, 1995). The strengths perspective does not deny the grip and thrall of addictions and how they can morally and physically sink the spirit and possibility of any individual. It does deny that most people are victims of abuse or of their own rampant appetites (Saleebey, 1995).

The key word to the strengths perspective is empowerment. It means assisting individuals, families and communities in discovering and using resources and tools within and around them (Kaplan and Girard, 1994). To assist individuals with substance abuse and their families it is necessary to profile the user and their family, explore the family stress and assess the family coping. The profile need to be later interrelated to look at the strengths of the family in terms of flexibility in the family functioning. This would reveal the pattern of family adaptability among substance abusers. While doing so there is a need to compare between substance use groups and a normative population from the same area devoid of such problems.