CHAPTER I

INTRODUCTION

‘After he would tell me he overdosed and passed out for two hours, I’d say "John, why don’t you do a proper job?" I often felt he is better off dead’.

- Rachel, mother of a heroin addict.

As William Osler has rightly pointed out, perhaps, the greatest feature which distinguishes man from other animals, is his desire to take medicine. From time immemorial mankind has taken pleasure in consuming substances which affect the mental state of the individual. In some communities the use of it carried their own particular taboos, in certain other communities the use of it was considered to be religious. Today, drug culture has become widespread and extensive. The problem of drug dependence is growing like cancer and very much like cancer our intervention programmes seem to have no effect on its growth. From what can be seen, heard and read from various means of mass media, it is apparent that drug abuse is a complex and multifaceted problem. Although the motivating factors for the initiation of drug use were found to be the tendency to seek pleasure and relief of pain, curiosity, peer pressure, boredom, frustration and so on, the different social, economic and political factors that predispose, precipitate and perpetuate the problem are to be attacked simultaneously to free our society from drugs.
Drugs - A Closer Look

Perhaps, the most fundamental and persistent question which basic pharmacology must address and to which the answer is continually evolving is "what is a drug?". Looking into the history of the concept of drug, it can be seen that the ancient Greeks called drugs 'pharmakon', a word which meant both poison and medicine. Similarly, 'pharmakevein' was either the practice of witchcraft or the use of medicine depending on the context. These simplistic concepts, reflective of a certain ambivalence, represented the attempt of Greek society to come to terms with the powerful effects of drugs on the mind and body of the individual.

Even in more recent times, society has had great difficulty in arriving at one satisfactory definition of the word. According to the existing viewpoint, in the case of both pharmaceutical preparations and naturally occurring substances, a substance is a drug whenever its use is intended primarily to bring about change in some existing process or state, be it psychological, or biochemical. The intended modification can be directed towards changes in medical, behavioural or perceptual states and for either therapeutic or non-medical purposes.

Thus it is evident from these definitions that a vast number of substances from a wide variety of sources may be considered to be drugs. However, for the purpose of the present study, only those drugs which have, either as primary or secondary characteristics, mood altering properties (psychoactive drugs), are taken into consideration.

Psychoactive drugs can be divided into three major types according to their source: naturally occurring, semi-synthetic and synthetic. Certain
plants and animal tissues contain psychoactive drugs, in some cases the crude material is used as the drug preparation while in other cases the drug substances are extracted and purified. These drugs are generally described as 'naturally occurring. For example, the stimulant cocaine, contained in the leaves of the Erythroxylum coca shrub, has been in both medical and non-medical use for hundreds of years. The active alkaloid, cocaine, is easily extracted from the plant by chewing or pressing the leaves. Chemical manipulations of psychoactive substances which have been extracted from natural materials may result in drugs with somewhat different properties. These drugs are called semi-synthetics. Heroin (diacetylmorphine), for example, is prepared in the laboratory from the natural product, morphine in chemical combination with another substance, acetic anhydride or acetyl chloride. Psychoactive agents neither found in nature nor derived from natural psychoactive agents are known as synthetics, they are created entirely by laboratory manipulation of two or more relatively simple chemicals which in themselves are usually psycho-actively inert. Methadone is an example for a synthetic drug.

The different drug classes as is given by the Addiction Research Foundation of Canada are as follows:

1. Central Nervous System (CNS) Depressants
   a. Sedative/Hypnotics
   b. Minor Tranquilizers

2. Hallucinogens
3. Mood Modifiers
   a. Major Tranquilizers.
   b. Antidepressants (Mood Elevators)

4. Narcotic Analgesics

5. Stimulants.

**International drug scene:**

Drug addiction is a menace that is spreading all over the world at an alarming rate. WHO reports that nearly 50 million people in the world are drug-addicts, 30 million smoke marijuana, eight million cocaine, 1.7 million opium, 700,000 use heroin and the remaining consume narcotics such as smack etc. In U.S.A drug-abuse is the number one health problem. Number of Americans using various drugs, being addicted to them, and even dying from overdoses, is on the increase. It is estimated that Americans spend about $90 billion a year on drugs. The various cities in the U.S., where use of drugs and drug related crimes are high are Detroit, Texas, Miami, Boston and Los Angeles.

Cannabis is the most used drug in Africa and the middle East, where it was unknown till 1940.

Pakistan and Bangladesh in the subcontinent show an unprecedented rise in drug abuse. Drug-abuse in the Gulf and the West Asian Countries is also on the rise, cannabis and opium being the commonly used drugs.
Pakistan is the most convenient point for smuggling out huge quantity of drugs like opium, heroin, smack and mandrax. Latin America is also a haven for drug trafficking.

Bolivia and the neighbouring countries grow and process cocaine. South America has an enormous trade in cocaine.

The US war with the drug cartels in Columbia throws light on the fact as to how powerful and what far-reaching consequences drug trafficking has. Drug is being smuggled through various routes, Venezuela being the popular transshipment point for East bound cargo. Cocaine primarily travels from Colombia Pacific ports, via Costa Rica to Mexico and on to California. Drugs are also moved through Chile to markets in Asia, and through Brazil, Uruguay and Argentina to Europe.

"Golden Triangle" comprising the border areas of Thailand, Burma and Laos was once the main source of supply. But now the "Golden Crescent" (comprising Iran, Pakistan and Afghanistan) has taken over the main supply. Drug trafficking has a well organized network all over Europe and America and other regions. Drug traffickers, transport crude opium from Turkey into Africa and convert it into a crude form of morphine. This is then transported to European countries, mainly the French port of Marseilles, where a further conversion to heroin takes place. Then it is smuggled to other parts of the world, mainly U.S.A.

**Epidemiology of Drug Abuse in India**

Intoxicating Drugs are not new to India. The Vedas mention 'somaras', an intoxicant used during certain occasions. Earliest reference
to cannabis (Indian Hemp) is found in 800 B.C. and by 1000 AD, its use became fairly common. It appears to be the favourite drink of Lord Shiva. In the Vishwanath temple (temple of Shiva) at Varanasi, the Datura fruit is an essential offering. A large number of sadhus or ascetics are believed to be using these drugs to experience hallucination and a sense of feeling of timelessness. There is evidence that poppy was cultivated in Canbay and Malva, during the 15th century. Moghuls recognized opium as a vital article of trade. In 1757, the East India Company monopolized cultivation of poppy. Governor General Warren Hastings brought opium trade under the control of the Government.

In many parts of the country pseudo-religious tradition sanctions the use of cannabis, opium, charas and ganja. They have also been used for self medication, and as sedatives.

It is considered that drug problem faced by India is, to a great extent, due to the country’s geographical position. India is located between the two major points of origins of illicit drugs - the Golden Triangle countries of Burma, Thailand and Laos in the East and, the Golden Crescent countries of Pakistan, Afghanistan and Iran in the West. The two main transit points in India are Bombay and Cochin.

Drug trade started in earnest only in the eighties. Smack, which is a derivative of heroin was almost unknown in India till 1980. In 1981, the first seizure of heroin took place, 17 cases were seized with only 8 kg of heroin. In 1987, the seizure was of 2,747 kg in 351 cases, and 3029 kg in 489 cases in 1988, and almost double the amount of this was
seized in 1989. The seizures account for just 10% of the total trafficking only.

India also produces, by illegal means, drugs like ganja and marijuana from cannabis plants. They are cultivated illegally in Tamil Nadu and Kerala, processed and sent abroad. The Central Excise Department raided the hills on the Tamil Nadu-Kerala border in February 1988, trekking from Madurai to Erumaithozhu in Atamalai hill near Theni, Tamil Nadu and seized 1,505 kg of processed ganja valued at Rs. 15,00,000 locally, and Rs. 3 crores in the international market. Bombay has over one and half lakh addicts whereas Delhi, which is now considered one of the leading drug cities of the world, has over 3 lakhs addicts. Drug abuse started coming to the forefront as a problem in Madras, only by 1987. It has more than 10,000 addicts. Drug addiction is seen more in North East India.

The report of ‘SPARC’ on policy perspective in management of drug abuse, states that there are thousands of farmers in Madhya Pradesh, Utterpradesh, Rajasthan, Hariyana, Kerala, Bihar, parts of Jammu and Kashmir, Himachal Pradesh, who cultivate opium and ganja. A large number of people in the North Indian States, depend solely on opium cultivation for their source of income.

The drugs introduced recently into the Indian drug scenario are Heroin, Brown Sugar, Pethedine, Morphine, Mandrax and Fortwin. These are the hardest form of addiction in India.
Metropolitan cities like Calcutta, Bombay, Bangalore etc. seem to be harbouring a large percentage of drug users. Trade in drugs has become a source of huge profit. The underworld elements carry out drug trafficking. India has become one of the pathways or route through which drug smuggling and trafficking is carried out to the West. Narcotic crimes are on the increase.

There are a large number of retail dealers in all parts of the country making small profits from the sale of charas and ganja. In the years 1969 to 1976, the total number of cases under the Arms Act, Opium Act, Excise Act, SIT Act was over 12,000, indicating a strong presence of organized crime in India. Narcotic terrorism has established its roots in India and is fast growing. Problem of Drug abuse is growing up inspite of the preventive and treatment facilities. It is also interesting to note that reports on drug abuse are not available from various parts of the country due to lack of researches conducted in those areas. This shows the alarming rate of drug abuse in India. Unless this is nipped in the bud, it is going to destroy the Indian Society.

Drug Abuse in Kerala

The North Eastern hilly region in Idduki district produces ganja on a large scale. Between September 1987 and May 1988 over 600 acres of ganja plantation worth Rs. 69 crores were destroyed. Besides Ganja, Brown sugar is also being used widely in different parts of Kerala.

Tourists centres have become the circulative areas for trade. Tourists spots, like Kovalam, Thekaddy etc. attract both foreign as well as Indian tourists, and thereby selling becomes easy. Incidence of drug
abuse and trade is increasing in other parts of Kerala, like Trivandrum, Ernakulam, Trichur, Quilon, Cannore, Kasargod, Calicut, towns of Varkala, Pathanamthitta and Chavakkad. In Kerala the cities and towns are closely interconnected, and close to each other as perhaps in no other state and so trafficking becomes easy.

The Police had launched a massive operation against cultivation of drugs and trafficking of drugs. Hundreds of thousands of acres of Ganja plants were destroyed. In Kochi notably, the police has succeeded to some extent in curtailing drug trade. The massive arrests indicate the growing problem. Police themselves admit that there is at least ten unidentified cases to every case that is arrested.

Drug abuse is becoming a major problem in Kerala. It may be due to the following factors:-

1. Large number of educated unemployed youth.

2. Ready cash available due to large number of persons working in the Gulf countries.

Family Situations and Drug Abuse

Family structure principles:

Technically, Family is a unit consisting of married male and female and their offspring, and such a family is called the monogamous nuclear family. This type of family is the most familiar today. Yet, when the family structures are viewed cross culturally, the variations from this pattern is seen to be enormous. These variations are based upon such structural issues as the number of persons of each sex who are
allowed to marry, the expected composition, including both marital units and blood kin, and the pattern of residential clustering of kin.

**Marriage arrangements and types:**

Basically, there are two types of marriages.

1. **Monogamy** - in which only one male and one female are allowed to marry each other.

2. Polygamy or multiple marriages, which involves more than one member of one or both sexes. Polygamous marriages are of three types.

   a) Two or more females may be married to one male - "polygamy" or "many wives".

   b) Two or more males may be married to one female - "polyandry" or "many husbands".

   c) Two or more males might be married to two or more females - "group marriage". (Murdock, 1957)

**Universal family functions:**

In order to continue existing, the society has to accomplish certain goals - the dying must be replaced by reproducing individuals, it must protect its boundaries, motivate persons to take positions of leaderships, it must solve the economic problems and physical survival and so on. (Aberle, 1950).
There are some functions that appear to be performed by the family in every society. These are called "Universal Family Functions" or functions that the family has always carried out everywhere. Kingsley Davis speaks of reproduction, maintenance, placement and socialization (or raising the young) as universal family functions. According to George P. Murdock the universal family functions are reproduction, socialization, economic cooperation and sexual relations. But Ira Reiss claims that there is but one universal function of the family - the "nurturant" socialization of the newborn. Generally, it can be said that a family has to perform the following functions:

1. Reproductive function or replacement function.

2. Status placement or interrogative or maintenance function.

3. Socialization or child rearing function or the social control function. (Reiss, 1965)

Description of family system:

In the manual 'Family system' written and compiled by The Johnson Institute, it is stated that each family is unique; and no two are exactly alike. Even so, all families have some traits and characteristics in common. An observed fact over the past several years is that all families tend to react in patterned and predictable ways when one member of the family becomes a drug addict.

Family usually consists of a mother, a father and some children, who are dependent on one another for meeting their social, emotional, spiritual and physical needs. "Family" could be extended to include other
people who become family members through birth, marriage, legal adoption or less formal ways such as becoming a part of the family by participating in family functions by lending support during troubled times and by sharing other family activities.

Each member of the family experiences the pain, suffering, joy and success of the family as a whole. The family as a whole experiences events in a way that non-family members cannot experience. If a chart is drawn to show ‘what goes on’ in the family, it can be seen that at one end of the line there is a nurturing atmosphere, where members love and like each other, and respect each other. Such a family lives more or less happily and is emotionally secure because there is trust and support in the family. At the other end of the line is an atmosphere of dysfunction. Hence, there are big problems that cause family members great pain and insecurity, and they show their pain and insecurity through inappropriate anger, aloofness, resentment and sometimes through chemical dependency.

Every family system moves between a nurturing atmosphere and a dysfunctional one. At any given time, every family is some where on this continuum. As a result of events that occur in the system, the family, as a group can move in either direction.

In a healthy family system, all the members in the family are able to feel free to express their emotions to each other and to feel a full range of emotions. Conflicts or problems are not avoided, differences are talked over. There is respect for each other in the family. By
working through their problems and their differences, members of this family are able to face stress and pain.

However, the family begins to move toward the dysfunctional end of the continuum, when a family member becomes chemically dependent.

Chemical dependency is a disease that may start with one person but eventually it will involve each member of the family in a dysfunctional family system. Every member of a chemically dependent family, without doubt, plays a part in the malfunction. And each family member requires help in breaking this destructive pattern.

The Addict and the Family

Addiction is contagious. It is not the drugs that is contagious, but their impact on the family.

According to Melvyn Bowler, a private drug counsellor, the family's first response to addiction is denial and the addict's behaviour will be attributed to anything other than drugs. When reality dawns, the parent or partner begins to try various coercive methods in an effort to stop the addict's habit. They try all sorts of methods to put an end to addiction and their efforts can continue for years. Patience gradually wears down. Members feel a loss of love for each other. The attention given to the addict is withdrawn and the addict retreats. The process continues.

Dr. Elisabeth Kubler Ross's description of the path towards accepting death (in the book on Death and Dying), is often used to explain how families react to an addict in their midst. The progressive
steps charted by Dr. Kubler are denial and isolation, anger, bargaining, depression and acceptance.

The progression through these steps may vary from individual to individual. Sometimes people become stuck at one stage, or stages double up. It is through the way the family adjusts to life with the addict, and the way the addict disentangles from the emotional relationship with his/her dependency, that the evolution from denial to acceptance is witnessed.

In trying to change the addict’s ways, the family members see themselves as victims of the addict’s wiles and deceptions, and they join the game in the hope of outsmarting the opponent. The family is drawn in not only for the survival of the addict but also for the survival of the family as a whole. Trying to find a solution, the family goes in all directions. The family accuses the addicts and stops providing money or feels guilty, tries to find what mistake they have made for driving the addict to take drugs (Levinson).

Because of the social attitude towards drug addiction, families of addicts might feel a confusing mixture of revulsion and self-loathing. Society either pities the addict or despise him or her. Due to such reasons, family members keep this secret even from their closet kin and friends. Members of family begin to lose their sense of direction, they become emotionally paralyzed. They lose their perspective on what kind of behaviour is acceptable. Their good judgment evaporates.
Sisters and brothers of addicts:

The most overlooked, in the middle of addiction chaos, are perhaps the siblings of the addict. They feel frustrated, angry, guilty and ashamed. They do not know which position to take, the addict’s side or the parents side. They are unconsciously side lined by the parents, by giving all time and attention to the addict. Sometimes they emulate their addict sibling as a demonstration that they require some attention.

Communication is the worst hit area. The family feels very touchy about subjects related to addiction, and thus silence clamps down on anything that matters. This can damage the young children present in the family.

Influence of the Family on Drug Addicts

The importance of family environment especially of parents, in determining the psychological and social adjustment of children has been long recognized. However, the optimal parenting practices have not been identified. There are two characteristics of parenting which have received primary attention - autonomy versus control, and warmth and support versus rejection (Medinnus and Johnson 1969, Rollin and Thomas 1979).

The amount within each type of control parents exercise on their children is very important. Rollins and Thomas (1979) have differentiated three methods of control - coercion, love induction and withdrawal. Coercion includes physical punishment, deprivation of objects or privileges, and threats of punishment or deprivation. This has been consistently related with negative outcome. It is seen that as the degree of coercion increases,
social competence decreases and social problems, such as antisocial aggression, behaviour problems and drug abuse increase. It is seen that through inductive control, where parents seek voluntary compliance with rules through reason, competence is developed. Lack of consistency has been shown to have a negative impact on the development of children. (e.g. Block 1971, Bechen 1964).

**Family Systems and Family Therapy of Substance Abuse**

The field of family therapy began when a group of researchers from the Mental Research Institution Palo Alto, California, decided to see schizophrenics in their family setting (Bateson, Jackson, Haley and Weakland 1956). They wanted to see the interaction between the family members.

Family therapy is the treatment of choice since the family is deeply involved in the addictive system (Coleman and Stanton 1978).

Significant and substantial progress has been made in the study of family systems and in the field of family therapy. Many treatment methods have been developed in the family therapy, to motivate substance abusers, detoxify them and work with the family when the identified patient is not involved in treatment, and to restructure the entire family. Transition that the family undergoes due to the presence of an addict member is very difficult. Family therapy helps the family to go through these transitions, also aid in the transitions by promoting the development of subunits (parents, siblings, individuals, procreated families), development of attitudes and skills that would lead to independent living (Haley, 1980; Minuchin, 1974).
Family therapy is still in its infant stage. But, even then, it has made great strides in the therapy of substance abuse. It has evolved from a virtually non-existent state to a treatment modality of proven worth. Family therapy's progress is based on the growth in two major aspects of the field; the study of family systems and the application of new techniques in the fields of family therapy to substance abuse.

Thus, it can be seen that family plays an important role in the general development of children and particularly in the children's risk of drug abuse. This points to the need for drug abuse prevention approaches that focus on the family. With this in mind, the researcher focuses his study on the families of drug addicts taking in purview their family functioning and social support system.