Chapter-I

INTRODUCTION
Chapter 1

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The problem of drug abuse is not unique either to India or to the present times. It has been a feature of all societies in the world since time immemorial, and has arisen out of the rapeutic and hedonistic considerations or as a means of escape from the reality of life's stresses and strains. The substances used for these purposes have also varied from society to society and from time to time depending upon the development of science and technology. Modern Indian society is being rapidly industrialized and urbanized especially in the post independence period. The spread of secondary and higher education has also created an elite group which is increasingly adopting the lifestyles of and value systems of the highly industrialized society of the West. Under such circumstances, it is hardly a matter of surprise if the above friends, which are seen in all industrialized and modern societies, should also manifest themselves in India.

It is also a matter of fact that from the very beginning, cannabis drugs have been in use in India. Ancient books are replete with references to intoxicants such as 'soma rasa', 'dev booty', 'madira' etc. Opium became popular during the Mughal period. The post war period saw the rise of synthetic drugs-both
stimulant and depressant. Hard drugs such as heroin and lysergic acid hydrochloride (LSD) are in use. Recently discovered hallucinogens such as phencyclidine hydrochloride (Angel Dust) may also be known to certain users in metropolitan areas. Nevertheless, it is difficult to assert that the prevalent rate of psychoactive drugs in the country is comparable to that found in many western countries. However, the problem has often been associated with the processes of urbanization and modernization. As a developing country, India is very much in the throes of these processes and hence, the drug scene in the country needs to be watched.

Moreover, the abuse of drugs and alcohol is an international problem which affects almost every country in the world both developed and developing. The many health, social, economic problems and even deaths associated with such abuse are the result of a complex interaction between the drug, the individual and the setting in which the drug is taken. The total costs to society for each category of drug abuse are difficult to determine exactly because of the paucity of adequate data, but there is no doubt that every country in the world incurs substantial costs as a result of the direct and indirect damage caused by drugs and alcohol. The authorities have not been oblivious to the immediate and anticipated dangers posed by the problems. On the contrary, action taken by policy makers has resulted in a substantial curbing on the use of cocaine and
opium. Prohibitionist policies have been experimented with containing the use of alcoholic beverages but their success has thus far been elusive. Drug laws are reportedly being updated and rendered problem oriented as compared to being excise-oriented.

The drug problem has also been the subject of considerable research. Impressionistic articles, journalistic accounts and scientific papers and reports have been published. However, empirical researches conducted in the past are mainly based upon nature, extent, types, causes and impact of the drug. Hardly, a few attempts have been made to understand the psychosocial characteristics of the drug users. With these considerations in mind, the purpose of the present study is to explore the nature, extent, cause and impact of the drug abuse in general and the psychosocial characteristics of the drug users in particular.

**Meaning and Concept of Drug & Drug Abuse:**

There are diverse opinions regarding the nature and definition of drug, drug addict and drug addiction. Before defining drug addiction it is essential to know what drug means. National Commission on Marijuana and Drug Abuse, USA (1973) define drug as “Any substance other than food which by its chemical nature affects the structure or function of a living
organism.” Similarly, McConnell (1977) has stated that, “A drug is any chemical which, when taken in relatively small amount significantly increases or decrease cellular activities somewhere in the body.”

Accordingly “ A drug is any chemical that affects the rate of function of a biological system”(Lather, 1993). McMohan (1977) remarked that “alcohol is a drug, of course, just as much as heroine and marijuana…drugs refer to those mind-altering substances whose sale without a prescription is illegal…” In the psychological sense, drugs serve the same general function as alcohol; they provide escape mechanisms in various degrees to run away from realities of life.

And on the other hand, “The term ‘addict’ means any person who habitually uses any habit forming narcotic drug……..so as to endanger public morals, health, safety, or, welfare, or who is, or has been so far addicted to the use of such habit-forming narcotic drug as to have lost the power of self control with reference to his addiction (Pescor, 1952). According to Aussbel(1954) “drug addict is a person who has selected drugs as a way of avoiding the realities of life there must be access to drugs.” World Health Organization (1957) defined addiction as a state of periodic or chronic intoxication which is detrimental to both the individual and society and which is produced by repeated consumption of natural or synthetic drugs. Buss (1978) describes addiction in terms of continuum of abnormality and
states that "addiction to alcohol, heroin, and other drugs are not only abnormal in the sense that they are excessive behaviors but are also serious threat to health and addiction leads to cumulative problems, because addicts usually acquire more and more of the drug leading to physiological accommodation to the drug..." Characteristically an addict has an overpowering need or compulsion to continue taking the drug, no matter what means may be required to secure the supply of it. They have a tendency towards the increasing the quantity of the dose taken which leads to a psychological and physiological dependence on the effects produced by the drugs.

Drug dependency is still a different phenomenon. However, it is nearer to the term drug addiction than drug habituation. White and Watt (1973) defined drug dependency as, "The process of chemicals that affect the central nervous system (CNS) in a way experienced as pleasurable but hazardous to health if taken in immoderate amounts." Drug dependence is a condition of psychological or physiological dependency which follows the periodic or continuous administration of a drug. Characteristics vary with the particular drug and must be made clear by the designation of the specific pattern of drug dependence in each case.

At present, some psychologists have used 'drug dependence' on the place of the word 'drug addiction'. Why should the word 'dependence' be preferred today to 'addiction'
in scientific terminology and the term was introduced by WHO Expert Committee in 1964, and defined as “A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioral and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomforts of its absence”.

This was done in the belief that the concept of addiction had become too narrowly associated with a stereotyped picture of opiate addiction, with the result that the severity and importance of compulsive condition associated with the other types of drug use were too often neglected or downgraded because they did not conform to this stereotype. It could, indeed, be argued that delay in appreciating the reality of the compulsive states that can be induced by, say, barbiturates, alcohol or amphetamines, was encouraged by the irrelevant belief that an addiction, to be a true ‘addiction’, had to conform exactly to the master model of opiate addiction. In contrast, the new WHO formulation emphasized the need to look at dependence as a spectrum of conditions, with both similarities and dissimilarities between the states produced by different drugs.

Eddy et al. (1965) have noted the numerous grounds which can be cited for objecting to the term addiction. The
acknowledgement that they are forced to settle for three terms, instead of a single term, to designate the varieties of problematical drug consumption that have been clinically referred to as drug-addiction, drug-habituation and drug-dependence. The term drug abuse, however, has a much wider connotation. It includes not only drug addiction but also other forms such as occasional, experimental and situational use or even a type of regular use which has no appreciable harmful effects. In fact, addiction is a process which begins from habituation (regular drug intake) to dependence (invariable craving for the drug) and resulting in addiction (the psychological and physiological dependence on drugs).

Therefore, the term ‘drug dependence’ has gained wide acceptance internationally, but the older word ‘addiction’ is so deeply rooted in everyday language that it will continue to be used for some time. We are, at present, in a phase where both the older and the newer words seem often to be used interchangeably and in much the same sense (Gossop and Grant, 1990).

**CLASSIFICATION OF DRUGS:**

The earliest records of man contain references to his familiarity with and use of various psychoactive drugs i.e., drugs which affect mental processes. Aside from alcohol, the
psychoactive drugs most commonly associated with dependence in our society would appear to be (1) the narcotics, such as opium and its derivatives; (2) the sedatives, such as, barbiturates; (3) the stimulants, such as, amphetamines; (4) the mild tranquilizers, such as, the meprobamates; and (5) the hallucinogens, such as marijuana, caffeine and nicotine are also drugs of dependence, but they are not included in the APA classification. World Health Organization (1973) recognizes the following as dependence producing drugs:

1. Alcohol-barbiturate type: ethanol, barbiturates and certain other drugs with sedative effects.
2. Amphetamine type: amphetamine, dexamphetamine, methamphetamine etc.
3. Cannabis type: marijuana (bhang, macocha, ganja, hashish and charas.
5. Hallucinogen type: LSD etc.
7. Opiate type: opiates such as morphine, heroin, codeine and synthetics with morphine.
8. Volatile solvent type: acetone etc.

Another way for classifying drugs is on the basis of the effect they have on the users. Accordingly, drugs can be
classified into the following types:

1. **Sedatives (mainly barbiturates):** Pentobarbital, secobarbital, barbital anobarbital.

2. **Stimulants (mainly amphetamines):** Benzedrine, Dexedrine, methedrine, cocaine, methaqualon and pep pills.

3. **Narcotics:** opium, morphine, codeine, heroin, methadone and pathedine.

4. **Psychedelics and Hallucinogens:** Cannabis, ganja, charas, bhang, hashish, mescaline, psilocybin and LSD.

5. **Tranquilizers:** Chlordiazepoxide, meprobamate, diazepam, scopolamine.

6. **Alcohol and tobacco**

7. **Miscellaneous:**
   
   (a) Sex stimulants
   
   (b) Mendrex

In brief all dependence producing drugs can be divided into four groups:

1. **Depressants:** They are synthetic drugs which have a depressant action on the central nervous system. Effect similar to tranquilizers. Sedatives, such as methaqualone; barbiturates, such as pentobarbital; tranquilizers such as Angel dust etc., are main depressant drugs. Its overdoses often result in slurred
speech, staggering, quick temper, drowsiness, quarrelsome disposition and death.

2. Stimulants: Stimulants are natural and synthetic drugs which have a strong stimulating action on the central nervous system. They bring a feeling of alertness and self-confidence. These are: amphetamines, diet pills, cocaine, caffeine and nicotine etc. cause excitation, talkativeness, insomnia, diarrhea, hallucination, increased blood pressure and frequent urination are some important manifestation of the overdose of stimulants. Although stimulants may not lead to physical addiction, tolerance is build up by the body so that larger and larger doses are needed to reach the desired result.

3. Hallucinogens: They are natural and synthetic drugs which affect the mind causing distortions in physical senses and mental reactions. These include LSD, mechaline, psilocybin, DNT (dimethyltryptamine), PCP and angel dust etc. Withdrawal from reality, panic and suicidal feelings, genetic damage, increasing blood pressure and temperature, irregular breathing etc. are manifestations of the overdose of hallucinogens.

4. Deliriants (Inhalants): Any chemicals which give off fumes or vapors which, when inhaled produce symptoms similar to intoxication are called the deliriants, i.e., sniffing, glue, gasoline,
lighter fluid, paint thinner, varnish, shellac, nail polish remover, aerosol-package products etc. These toxic vapors never intended to be breathed, cause physical damage to mind and body. Fumes can cause temporary blindness and damage to lungs, brain and liver.

**Extent of Drug Abuse**

On one hand, drugs such as cannabis and opiates, which have been in use over a period of time, may be termed as traditional drugs. On the other hand, drugs such as heroin, mescaline, LSD Angel Dust which are relatively recent in origin, may be called modern drugs. Apart from this, the form of drugs prevalent in rural areas in India differs from that in urban areas. It is also seen that particular drugs are widely used in certain countries. In the USA, Great Britain and Hong Kong, heroin is the most commonly abused drug. In China, it is opium and in Japan, it is amphetamines. In India, the abuse of cannabis and its derivatives in all forms exists, heroin being the next menace.

A number of surveys and clinical studies are available which throw light on the prevalence of different drugs. Because the sudden upswing in the incidence of drug usage has alarmed not only the doctors but also psychologists, sociologists and psychiatrists. US Bureau of Narcotics (1962) noted the gradual transition from one drug to another in the present century. The
era of 1900-1915 was mainly dominated by opium and opiates. Cocaine use gradually came into the scene in the same era (1900-1925) with opium still common. There was an upswing in drug trafficking and clandestine manufacturing of heroin and morphine in Europe and near east from 1920-1940. Between 1925-1940 cocaine use disappeared from the drug scene and opium use increased. Since 1946 till date, heroin addiction dominates the scene. Blum (1967) reported an overall incidence figure of 69% in a large private California university in 1967 as compared to only 21% who reported having used marijuana in 1966 in a similar study done at the school. Wikler (1967) reported that before world war II, narcotic addiction was distributed throughout America at a low level. After the war, it tended to concentrate in the slum areas of large metropolitan cities, particularly New York City. Rosen et. al., (1972) has stated that apart from the millions of occasional and experimental drug users, it was estimated that there were between 60,000 and 1,80,000 hard core addicts in the united states. In 1972, the popularity of heroin was spreading from big city ghettos to suburbs and rural areas, to college, high schools and even to elementary schools. New York State Office of Drug Abuse (1975) did a very elaborate study encompassing the whole state of New York involving 8553 subjects. It provided some interesting data on students in grades 7th to 12th. Alcohol was used by 81% of the students, but marijuana only by 31%,
9% used depressant and stimulants, 6% LSD, and 3% used actual narcotics. More or less a similar trend of results have been found from some other investigators in the West (Wilner & Kassebaum, 1965, Mills & Noyes, 1984).

Extent of drug use in the world population can be explained by “annual prevalence” as presented by World Drug Report (2006). Annual prevalence is a measure of the % of people who have used an illicit drug at least once in the 12 month period preceding the assessment. The annual prevalence estimate is derived from national survey results and extrapolations from partial information on the drug situation in the various countries.

Table – 1.01

Table 1.01: Extent of drug use (annual prevalence) estimates 2004/05:

<table>
<thead>
<tr>
<th></th>
<th>All illicit drugs</th>
<th>Cannabis</th>
<th>Amphetamine-type stimulus (ATS)</th>
<th>Opiates</th>
<th>Of which heroin</th>
<th>Cocaine</th>
</tr>
</thead>
<tbody>
<tr>
<td>(million people)</td>
<td>200</td>
<td>162.4</td>
<td>25</td>
<td>9.7</td>
<td>15.9</td>
<td>11.3</td>
</tr>
<tr>
<td>In % of Global pop.Age 15-64</td>
<td>4.9%</td>
<td>3.9%</td>
<td>0.5%</td>
<td>0.2%</td>
<td>0.4%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>
Table 1.01 shows that some 200 million people or 5% of world’s population aged between 15 and 64 years have used drugs at least once in the previous 12 months. Of all illicit drugs, cannabis remains by far the most widely used drugs. The number of cannabis users in the world surpassed the 160 million mark in 2005 and is now estimated at some 162 million people, or 4% of the world’s population in the age of 15-64.

With some 35 million users, amphetamine-type stimulants (ATS) are the second most widely used group of drugs in the world that is slightly higher than the previous year (2005). There is also an increase in the estimate of ecstasy users(22%), due to increased reporting of ecstasy use in developing countries, particularly in Asia. Its use in Europe is largely stable.

The global estimates of amphetamines users are now slightly lower, reflecting lower estimates for Asia, where more than 60% of the world’s amphetamines users are found. Amphetamines use in Europe and in the Americas remained largely stable.

The number of opiate users in the world remains stable at around 16 million people (of which 11 million people abuse heroin). This mainly reflects increasing levels of opiate abuse in some part of Asia (countries surrounding or close to Afghanistan).
Estimates of the number of cocaine users -- some 13 million people -- are slightly lower than last year. The estimates suggest that at the global level, at least, the upward trend in cocaine consumption has come to a halt, notably in the Americas. This positive trend, however, goes hand in hand with the observation that in a number of other countries cocaine consumption continues rising.

Global prevalence estimates suggest that overall drug use has been rising, over the last few years, mainly due to increased levels of cannabis and ecstasy use. (World Drug Report 2006 Vol. 2. Statistics).

In India, Chopra & Chopra (1965) have written much about the use of intoxicants, particularly about cannabis and opium in Indian society. Bannerjee (1963) studied drug abuse among Calcutta University students with a sample of 1132 subjects prevalence rate found was 37.4%(20% for tobacco, 11.4% for amphetamines and rest for other drugs. In a study conducted in Lucknow, Thackore et. al. (1971) noted that 12 out of 57 medical students (21%) who sought psychiatric help over a period of 4 years had a history of drug abuse at sometime. Out of these 12 subjects, 8 has used amphetamines, 3 alcohol, and alcohol plus cannabis. In a study reported by Delhi School of Social Work (1972) among 100 graduate and post graduate students, the various drugs abused, cannabis preparations were found to be most popular(95%) , followed by meldon (49%)
and LSD(18%).

In 1976, the Ministry of Social Welfare of the Government of India launched a multi-centre research program covering several urban centers including Mumbai, Delhi, Chennai, Hyderabad, Jabalpur, Jaipur and Varanasi. The sample (N=25,000 approximately) covered both male and female students who were pursuing generic as well as professional courses. (See tables- 1.02, 1.03, & 1.04)

Table 1.02
Drug users in study centers

<table>
<thead>
<tr>
<th>Centre</th>
<th>Non-users %</th>
<th>Former users %</th>
<th>Current users %</th>
<th>Sample size (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bombay</td>
<td>57.8</td>
<td>6.7</td>
<td>35.0</td>
<td>4151</td>
</tr>
<tr>
<td>Delhi</td>
<td>52.5</td>
<td>12.9</td>
<td>34.6</td>
<td>3991</td>
</tr>
<tr>
<td>Hyderabad</td>
<td>77.8</td>
<td>4.9</td>
<td>17.1</td>
<td>903</td>
</tr>
<tr>
<td>Jabalpur</td>
<td>56.4</td>
<td>14.1</td>
<td>29.5</td>
<td>4415</td>
</tr>
<tr>
<td>Jaipur</td>
<td>77.6</td>
<td>3.9</td>
<td>18.5</td>
<td>4081</td>
</tr>
<tr>
<td>Madras</td>
<td>76.8</td>
<td>3.7</td>
<td>19.5</td>
<td>3580</td>
</tr>
<tr>
<td>Varanasi</td>
<td>54.6</td>
<td>11.8</td>
<td>33.5</td>
<td>3852</td>
</tr>
<tr>
<td>Total</td>
<td>62.9</td>
<td>8.9</td>
<td>28.2</td>
<td>24973</td>
</tr>
</tbody>
</table>

Source: Khan and Singh (1979).
Table 1.03
Prevalence rate of drug use by substance (%)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>15.1</td>
<td>12.2</td>
<td>8.6</td>
<td>9.4</td>
<td>9.7</td>
<td>9.4</td>
<td>10.4</td>
<td>10.2</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>0.2</td>
<td>0.3</td>
<td>0.05</td>
<td>0.2</td>
<td>0.05</td>
<td>0.4</td>
<td>1.3</td>
<td>0.5</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
<td>0.7</td>
<td>0.4</td>
<td>1.5</td>
<td>1.8</td>
<td>0.7</td>
</tr>
<tr>
<td>Cannabis</td>
<td>0.4</td>
<td>1.3</td>
<td>0.80</td>
<td>8.5</td>
<td>0.9</td>
<td>1.5</td>
<td>11.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.05</td>
<td>0.03</td>
<td>0.1</td>
<td>0.2</td>
<td>0.09</td>
<td>-</td>
<td>0.6</td>
<td>0.1</td>
</tr>
<tr>
<td>LSD</td>
<td>0.07</td>
<td>0.2</td>
<td>-</td>
<td>0.2</td>
<td>0.2</td>
<td>0.4</td>
<td>0.9</td>
<td>0.3</td>
</tr>
<tr>
<td>Opium, morphin &amp; heroin</td>
<td>0.4</td>
<td>0.5</td>
<td>0.2</td>
<td>0.3</td>
<td>0.2</td>
<td>0.4</td>
<td>0.9</td>
<td>0.4</td>
</tr>
<tr>
<td>Analgesic</td>
<td>12.6</td>
<td>20.9</td>
<td>2.8</td>
<td>15.1</td>
<td>2.3</td>
<td>1.4</td>
<td>13.8</td>
<td>9.2</td>
</tr>
<tr>
<td>Pethidine</td>
<td>9.1</td>
<td>10.5</td>
<td>5.3</td>
<td>18.8</td>
<td>9.2</td>
<td>15.2</td>
<td>15.1</td>
<td>9.9</td>
</tr>
<tr>
<td>Tobacco</td>
<td>1.0</td>
<td>2.9</td>
<td>2.6</td>
<td>1.2</td>
<td>1.2</td>
<td>1.1</td>
<td>2.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Khan and Singh (1979)
Table 1.04

Prevalence rates of drug use by sex of the respondents (%)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Males (N=1640)</th>
<th>Females (N=8573)</th>
<th>Total (24973)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>13.3</td>
<td>3.4</td>
<td>10.2</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>0.6</td>
<td>0.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>1.0</td>
<td>0.2</td>
<td>0.7</td>
</tr>
<tr>
<td>Cannabis</td>
<td>4.1</td>
<td>0.3</td>
<td>2.8</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.2</td>
<td></td>
<td>0.1</td>
</tr>
<tr>
<td>LSD</td>
<td>0.4</td>
<td>0.05</td>
<td>0.3</td>
</tr>
<tr>
<td>Opium,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>0.6</td>
<td>0.1</td>
<td>0.4</td>
</tr>
<tr>
<td>&amp; heroin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analgesic</td>
<td>8.6</td>
<td>9.9</td>
<td>9.2</td>
</tr>
<tr>
<td>Pethidine</td>
<td>0.4</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>Tobacco</td>
<td>14.4</td>
<td>1.3</td>
<td>9.9</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>1.8</td>
<td>0.9</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Source: Khan and Singh (1979).

Table-1.02 shows that less than two thirds of the students were found to be non-users. Nevertheless, more than 28% of them took drugs. The proportion of the students who had reportedly never experimented with psychotropic drugs was the highest in Hyderabad (77.8%), followed by Jaipur and Madras. Perhaps the social milieu in these urban centres discouraged the
use of habit-forming drugs. Jabalpur had the largest proportion of the students (14.1%) who experimented earlier with drugs but had give up with no intention to resume. Bombay had the largest proportion (35.5%) of current users.

Which psychotropic drugs do students prefer? Table-1.03 shows that alcohol (10.2%), closely followed by tobacco (9.9%) is the most popular. The prevalence rate of drugs such as amphetamines, barbiturates, cocaine, LSD, opiates and pethidine is relatively insignificant. It is noteworthy that several modern drugs such as heroin and LSD are prohibitively expensive. Yet another fact which deserves notice is that in Varanasi and Jabalpur, cannabis drugs appear to be widely used. Table-1.04 indicates that alcohol (13.3%) and pethidine (14.40%) are prevailing more in males, whereas, morphine & heroin (9.9%) are prevailing more in females.

Drug Users

Studies conducted in India and abroad reveal that drug addiction is more and more prevailing in a certain age, sex, marital status, educational status, religion, and region and caste groups. Bewley and Ben Arie (1968) found that the mean age of male heroin addicts was 24.7 years for those born in England and Ireland and 33.5 for those born overseas. Ball and Chambers (1970) found that the mean age of addicts was 32.9
years for males and 33.5 years for females. They noted that most addicts were young (80% were under 40). Peterson (1980) found that more than 50 millions American had tried marijuana and millions used it regularly and use was particularly high in the age range of 18-25 years.

In the Indian context, Kodandarm & Murthy (1979) observed drug abuse to be most prevalent during adolescence and early adulthood. The frequency of drug use was reported to increase with age (Khan & Singh, 1979). Accordingly, the proportion of older students among those who had been using drugs for a long time was higher. Ahuja (1978) reported that the age group of 16-21 years is the most crucial in developing the habit of consuming drugs. Ahuja (1982) further reported that a little more than one-fourth (26%) were 18 years of age or less, nearly three-fifth (62.6%) belonged to 19-24 years age group and about one-tenth (9.7%) were more than 25 years of age. The findings of Bagadia and others (1981), Murthy & Kapoor (1981) and Veeraraghavan (1981) are almost similar. Malhotra and others (1978) report that drug addicts, as compared with alcoholics, are young. The highest proportion of cannabis users in the study conducted by Dube & Others (1975) was in the age group 15-24 years. Khan et al. (1979) reported current users to be marginally older than former users. Dev (1980) observed that drug taking starts around 17.5 years of age. Mohan and others (1980) reported that more than 50% of the villagers had
started taking alcohol before the age of 25 years. These studies clearly show that adolescents and youths are given to use drugs.

Evidence that drug use is more common among males than females is convincing (Wellisch & Hays, 1974; Castro & Valencia, 1980). In the Indian context, Dube and Others (1977), while studying medical and non-medical students in northern India, found that drug abuse among male students was clearly more prevalent than female students. In another study, Dubey and Others (1978) reported that male students preferred alcohol and bhang, while meprobamate, followed by alcohol, was more popular among females. Malhotra and others (1976) reported that the majority of psychiatric patients using drugs was male; but in the drug addiction group female representation was higher than in the alcoholic group. Khan and Unnithan (1979) observed that female students were not often involved in drug use but were not often involved in drug use but were proportionately over-represented in the category of current users as compared with former users. This suggests that, once having started taking drugs, female students are likely to continue using them. The multi-centre study also dealt with sex-differences among student drug users i.e., males are far greater drug users than females is amply shown by the data as presented in table 1.04. The data as presented in table 1.04 reveal that there are a few notable variations. In the use of analgesics, females outnumber males; in the use of alcoholic drinks, the formers
proportion is substantial; and the ratio between male-female drug users is as high as 3:4. Thus these findings corroborate those from elsewhere showing that males are more given to take drugs than females.

In the USA, hospital admission rates for alcoholics are estimated to be three times larger for the urban population than they are for the rural population. Sethi & Trivedi (1979) inquired into the use of habit-forming drugs in rural areas in a northern state of India. Deb & Jindal (1974) reported a prevalence rate of 74% of alcohol use in the rural areas of Punjab. Similarly, Dube & Others (1975) found that cannabis use was significantly associated with rural areas. In contrast, Malhotra & others (1978) reported that a greater number of drug addicts and alcoholic came from urban areas than from rural areas. A similar trend of data has been found by Ahuja (1978). Khan (1978) observed that cannabis was more popular with rural students, while alcohol and synthetic drugs were popular with urban students. Malhotra & others (1978) reported that Hindus were more prone to drug addiction (82%) and alcoholism (64%) than the followers of other religion. From the study of Dube & Others (1978) it was revealed that Hindus were highly associated with drug use (63%) and other religious groups (62%) than Muslims (40%). Verma and Others (1981) reported that Sikhs were over represented in the categories of 'current users' and 'ever users' while Murthy and Kapur (1981)
found that among Christian students in Bangalore, the use of alcohol and a few other drugs was reportedly conspicuous. Focusing on Jabalpur town, Khan (1978) observed that alcohol, tobacco and synthetic drugs were relatively more popular with Christians; cannabis drugs, with Hindus and Jains; tobacco and alcohol with Muslims; and alcohol with Sikhs. Dube and Others (1978) reported that among different caste groups there was hardly any difference between users and non-users, except that there were more bhang users among Brahmans and Vaishyas, and more ganja users among Kshatriyas. However, in a subsequent study Dube and Others (1978) found more users among higher castes (64.56%) than among lower castes (50%). Khan (1978) reported that alcohol was relatively more common among Brahmans, Vaishyas and Kayastha, and the use of tobacco among scheduled castes and scheduled tribes. In contrast, Khan and Unnithan (1979) reported an insignificant association between caste affiliation of the subjects and drug use.

Do married and unmarried persons differ in terms of drug habits? Khan (1978) reported that the proportion of married students in the categories of regular and habitual users was higher than that of unmarried ones. Bagadía and Others (1981) found chronic alcoholism distinctly high among married persons. On the contrary, Kadondaram and Murthy (1979) reported that drug use was prevalent among unmarried
criminals. A study conducted by Malhotra and Others (1978) to understand the relation between drug use and the level of education and they found that literates indulged in drugs (84%) and alcohol (91%) more than their illiterate counterparts.

On the basis of above discussion, it can be mentioned that the prevalence rate of drug use is relatively higher in adolescents, male, urban based, married, Hindu and upper caste subjects.

Causes of Drug Abuse

Since the beginning of history humans have searched for substances that would sustain and protect them and also act on the nervous system to produce pleasurable sensation. Individuals are attracted to drugs because drugs help them to adapt to an ever-changing environment. Smoking, drinking and taking drugs reduce tension and frustration, relieve boredom and fatigue, and in some cases help adolescents to escape the harsh realities of their world. Drug provides pleasure by giving inner peace, joy, relaxation, kaleidoscopic perception, surges of exhilaration, or prolonged heightened sensation. They may help some adolescents to get along better in their world. For example, amphetamines might help the adolescents to stay awake to study for an exam. Drugs also satisfy adolescents' curiosity - some adolescents take drugs because they are intrigued by sensational accounts of drugs in the media, while others may listen to a
popular song and wonder if the drugs described can provide them with unique, profound experiences. Drugs are also taken for social reasons, allowing adolescents to feel more comfortable and to enjoy the company of others (Ksir, Hart, and Ray 2006). But the use of drugs for personal gratification and temporary adaptation carries a very high price tag: drug dependence, personal and social disorganization and a predisposition, and a predisposition to serious and sometimes fatal diseases (Hales, 2006; Kinney, 2006; Ksir, 2000). Thus, what is intended as adaptive behavior is maladaptive in the long run. For example, prolonged cigarette smoking, in which the active drug is nicotine, is one of the most serious yet preventable health problems. Smoking has been described by some experts as "suicide in slow motion".

There is no dynamic picture that fits all drugs. However, depending on these drugs is commonly associated with a broader fabric of personality maladjustment, family structure and other psychological factors such as anxiety, stress and depression. Some other factors, such as relief of pain, SES etc. cannot be underrated.

Thus the factors of drug abusing can be described as follows:

1. **Family Environment & Drug Abuse:**

   In the family, family type, family size, birth order, status of family, parental attitude, parental deprivation, child rearing
practices and history of drug abuse in the family can be looked upon. In this connection, a lot of researches have been done in India and abroad. Chein et. al.(1964) contrasted the family background of addicts and normal controls. The addicts tended to come more often from families characterized by emotional disturbance, distance, poor father-son relationship and instability. O’Dowd (1974) examined one aspect of the family relationships, i.e., emotional support to determine whether supportiveness among family members correlated with the absence of illicit drug use. Bear and Corrado (1974) studied the role of parental influence in the etiology of heroin addiction. The addicts reported more physical punishment, more evening freedom as teenagers, less encouragement to bring friends home, less parental co-habitation, less career planning assistance and parents having less influence on their conduct. Majority of addicts lead an unhappy childhood which includes harsh physical punishment and a general pattern of parental neglect and rejection. Reilly (1984) reported that the social distance between parents and child increases so much that abusers put less value on their parents opinion. Bulk of drug abusers come from families where there is a communication gap and their laissez-fair or authoritarian discipline. In addition, drug abusers belong to families in which the person whom they defined as the most powerful tended to use psychological crutches to cope up with stress (Jurich ,et al., 1985). In India , Khan (1978)
reported a mild but inverse relation between parental control and drug use. This trend was further reinforced by the distribution of the user types (former users and current users) in relation to parental control (Khan & Unnithan, 1979).

Some studies conducted to know the relation between drug use and parental deprivation. Parental deprivation includes lack of parental presence whether due to death, separation or divorce. Fort (1954) found that father or father figure to be absent in most of the drug abuse cases. Chein et. al.,(1964) also reported, father or father figure to be totally absent in about half of their addict group. Needless to say that broken homes have been found to be more common in the background of addicts. Beecky (1971) found that 63% of the heroin addicts who got separated from parents knew that their fathers were still alive but had no communication with them. Malhotra (1983) who studied the familial and personal correlates of drug consumption among German Youth, found that drug consumption was higher in families in which one or both of the natural parents were absent. But contradictory remarks have been given by Ahuja (1982). It is not the father or mother absence but the quality of interpersonal relationship between the child and parents which is important in the incidence of drug usage. Lather (1993) has viewed that parental divorce seems to be related to drug problem more than parental death. Because separation due to divorce has alarming psychological impact than separation due to death.
The family as the primary socializing agent predisposes the individual towards deviancy or non-deviancy which includes use of hard narcotics. Bucky (1971) found that heroin addicts came from the largest families of all drug using groups. Delhi School of Social Work (1972) reported that 87% of the drug abusers came from joint families, 64% lived with families and 36% in the hostels. Khan (1978) divided students into two broad groups: (A) Those coming from nuclear family and (B) those from joint family: His findings revealed that there were comparatively more drug users in joint family groups than in single family groups. In sharp contrast, Veeraraghvan (1981) reported that students from nuclear family groups were more given to drugs. Birth order wise, drug abuse was more frequent in the middle than in other groups. Dubey and Others (1978), Murthy and Kapur (1981) and Khan (1978) observed that students coming from highly educated families had a higher drug use than those from low educated families.

Further, a good deal of association was observed between the family educational status and the extent of drug use by the students (Khan and Unnithan, 1979). Likewise, the current users come from better educated families (Khan & Unnithan, 1979).

Occupation has been studied in relation to drug use. Hartnoll & Mitcheson (1973) found that children with parents in white collar jobs (teachers, magistrate, police officer, social workers and legislators) were less given to drug abuse. The
cross-cultural study conducted by John and Others (1965) also revealed that drug use was more prevalent among persons engaged in low prestige occupation. Dube and Others (1978) found that drug abuse among students whose father were employed in occupations other than agriculture was higher. Conversely, Khan and Unnithan (1979) observed little or no correlation between family occupation and drug habits of students.

Some studies conducted in Indian context reveal that the use of drugs is positively linked with family income. Ahuja (1978) has found drug consumption to be high in upper income groups. Dube and Others (1978) reported that drug use among students who from families with a monthly income of Rs 500 and above was higher. Khan and Unnithan (1979) reported family income and the pocket money received as having a significant association with drug use.

Hartjen and Quinney (1971) and several others emphasized low family education and lower SES in relation drug use. On the other hand, Spencer and Navratnam (1980), while studying drug use among school children from 13-19 years of age in Malaysia, found that drug users did not necessarily belong to socially deprived classes. Khan (1978) observed that drug awareness levels tended to increase with SES: “The higher the SES of the respondent, the more likely he is to use psychotropic drugs or to turn regular/habitual users”.
Khan and Unnithan (1979) report that the current users primarily belonged to the higher strata of society, and the trend is further reinforced by yet another study (Khan and Unnithan, 1979 b). Another issue of importance on which several researchers have commented specially has been the factor of presence of drug abuse behavior in the other members of the family. Smart and Fejer (1972) found a positive relationship between parents' use of drug, alcohol and tobacco and the students' use of drugs of all kinds. More or less a similar trend of results have been found of the study of Morgado et. al. Different results were reported by Klinge (1983) and Verma et. al.(1977) reported that no relationship existed between adolescents and parents substance abuse.

Thus, it is evident that the family which is a primarily socializing agent can predispose the individual towards deviancy the individual towards deviancy. Parental attitude of rejection, inconsistent child-rearing practices, parental deprivation, drug use by parents and other family members, family structure, sibling position, income, occupation, SES of the family and disturbed patterns of the family play a vital role of escape from his self and society and ultimately indulge in one or more drugs.

**Anxiety and Drug Abuse**

Nervousness, fear and worry are common human responses that everyone, even rich and famous experiences at
one time or another. The characteristics of anxiety include feelings of uncertainty, helplessness and physiological arousal. A person who experiences anxiety complains of feeling nervous, pains, jumpy and irritable. These all conditions may motivate people to take drugs. According to Sarason and Sarason (2006) addiction is a general term that has been used to describe the harmful effects of excessive reliance on drugs for pleasure and relief of tension. They further argue that drug users are frequently prescribed tranquilizers to reduce anxiety and perhaps half a million Americans use them for non-medical purposes. Lindquist, C. U., et. al. (1998) administered measures of assertion, aggression, and social anxiety to a heroin-addicted population, psychotic outpatient, court-referred drug users and a college student group (N=114). The addicts and court-referred drug patients were less assertive, less socially assertive and more socially anxious than non-addict populations. Furthermore, the heroin and psychiatric outpatient groups had a very high correlation between their assertion and aggression scores, which was not found in the college student or court-referred, drug using group. In this connection, Tim Stockwell (1999) has rightly remarked that using alcohol to cope with stress is a common reason for drinking and alcohol has the pharmacological capability of reducing states of tension when used in moderate doses. This effect may, however, be dependent to some extent on the drinker’s faith as to its anxiolytic powers.
On the other hand, regular and heavy consumption of alcohol is likely to increase the risk of various mental health problems and enhance any states of ‘tension’. These conclusions highlight the importance of screening for alcohol abuse when attempting to intervene in any psychological or emotional problems. However, owing to the lack of empirical researches comparing drug user and non-user subjects in terms of their anxiety level in Indian society, nothing can be said conclusive.

**Stress & Drug Abuse**

Many clinical and addiction medicine specialists suggest that stress is the number one cause of relapse to drug abuse, including smoking. Now, research is elucidating a scientific basis for these clinical observations. In both people and animals, stress leads to an increase in the brain levels of a peptide known as corticotrophin releasing factor (CRF). The increased CRF levels in turn triggers a cascade of biological responses. Animal and human research has implicated this cascade in the pathophysiology of both substance use disorders and Posttraumatic Stress Disorder (PTSD) (Jacobsen, et al., 2001). Research also has shown that administering CRF or a chemical that mimics the action CRF in animals produces increases in stress-related behaviors. And, mice that lack a receptor for CRF (CRF1) have impaired stress responses and express less anxiety-related behavior. Furthermore, people subjected to chronic stress
or those who show symptoms of PTSD often have hormonal responses that are not properly regulated and do not return to normal when the stress is over. This may make these individuals more prone to stress-related illnesses and may prompt patients to relapse to drug use. Studies show that individuals exposed to stress are more likely to abuse alcohol and other drugs or undergo relapse (Sinha et.al. 2000; Dawes et. al., 2000).

In an analysis of studies regarding factors that can lead to continued drug use among opiate addicts, high stress was found to predict continued drug use (Brewer et.al.1998).

Some researches have shown that there is overlap between neurocircuits that respond to drugs and those that respond to stress (Kreek & Koob, 1998). A follow-up study of smokers who had completed a national smoking cessation program showed that there is a strong relationship between stress coping resources and the ability to sustain abstinence. (Matheny et. al., 1998). Acute stress can improve memory, whereas chronic stress can impair memory and may impair cognitive function (McEwan et. al.1995). Researches have shown that, among drug-free cocaine abusers in treatment, exposure to personal stress situation led to consistent and significant increases in cocaine craving, along with activation of emotional stress and a physiological stress response. In another study of cocaine abusers in treatment significant increases in cocaine and alcohol craving were observed with stress and drug cues imagery but not
with neutral-relaxing imagery (Sinha et al. 1999-2000). Animal studies have shown that stress induces relapse to heroin, cocaine, alcohol and nicotine Self-administration (Stewart et al. 2000).

**Depression and Drug Abuse**

During the past 15 years, research has been undertaken to examine the relationship between a variety of psychological and psychosocial variables and substance use. Among others, constructs such as depression. Bipolar disorder, anxiety, self-esteem, optimism or pessimism about the future, coping skills, and stress/tension have been investigated for their relationship to substance use. Such studies have presented mixed findings, but generally have shown that these states are related to drug use.

In many studies, depression has been linked to drug use, but the issue of causality has been very problematic for researchers to disentangle. That is, does drug use/abuse lead to depression? Does experiencing depression lead to greater problems associated with substance use? Do the two phenomena co-occur temporally and have a mutual (i.e., recursive) influence upon one another? The answer to these questions depends entirely upon whose research one consults. For example, a number of researchers have reported that the causal relationship should be conceived as drug use/abuse depression. Even in people who were not experiencing depressive symptoms prior to
their drug use. This has been reported for cannabis, alcohol, codeine, MDMA/Ecstasy and cocaine (Swendsen, Merikangas and Others 2000). Conversely, others have concluded that the causal relationship should be conceived as depression drug use/abuse in those who were not using or abusing drugs prior to experiencing depressive symptoms. Abraham and Fava (1999), for instance, studied people experiencing clinical depression and, by conducting life history interviews, determined that depression preceded all types of drug abuse (except LSD, which temporally co-occurred with the depression), typically by several years. Merikangas and Avenevoli (2000) reported that premorbid depression increases the chances that substance abuse disorders will develop. Others, whose work has focused on chemical dependency treatment outcomes, have reported that depression is associated with relapse among alcohol-addicted men (Strowig, 2000) and that reducing depression during the treatment process led to better treatment outcomes for methadone maintenance patients (Avants, Warburton, & Margolin, 2000).

To complicate matters even further, other researchers have found that alcohol dependence and depression were nearly evenly divided in terms of which came first among persons studied (Margolin, et al. 2000). Consistent with this research many studies have examined substance abuse disorders and depression, only to conclude that there is a substantial
overlapping in these two diagnoses, that the two conditions, often co-occur, and that temporally, they appear to form a relationship best conceptualized as drug use/abuse depression. This view of substance use/abuse and depression as having a comorbid or recursive relationship has been reported by McDowell and Clodfelter (2001); Mehrabian (2001); Melanin and Isometsae (2000); and Swendsen and Merikangas (2000); among many others.

Research has also been inconclusive with regard to the relationship between substance use/abuse and bipolar disorder. Some studies have reported that people suffering from bipolar disorder are more likely to develop substance abuse worsens bipolar disorder manifestations and the course and prognosis of bipolar disorder disease (Goldberg, 2001; Merikangas & Avenevoli, 2000). Other researchers have reported that substance abuse worsens bipolar disorder manifestations and the course and prognosis of bipolar disorder disease (Goldberg, Garno, Leon, Kocsis, & Portera, 1999; Strakowski, Delbello, Fleck, & Arndt, 2000). Still others have reported that substance use/abuse and bipolar disorder are comorbid conditions, with no apparent or easily determined causality (Goldberg, 2001; McQueen & Young, 2001; Strakowski, et. al., 2000). One study even draw four conclusions: for some people, substance abuse causes bipolar disorder; for others, bipolar disorder leads to substance abuse problems; for some people, an external factor
causes both substance abuse problems and bipolar disorder to co-occur; and finally, for others, bipolar disorder may lead to substance use as a form of self-medication (Strakowski & Delbello, 2000).

Other factors

In spite of the factors discussed to be above, attitude, interest, temperament,adjustive efficiency, curiosity of life, goals of individuals may have a decisive role in their taking drugs, from a psychological angle, many regards drugs as a "conscious induction device", and attempt to concept up their influence with "altered states of consciousness", "accelerated mental processes," "paranormal insights", "extra sensory perception" and the crossing of the "Threshold of spiritual perception" (Khan and Krishna, 1982).

Some researchers have brought attitudes towards drugs under focus; (Spencer and Navratnam, 1980), Dube and Others (1978) assessed the attitude of 1,000 students towards drugs and reported that the users of cannabis consistently had a favorable attitude towards its use. Likewise, Bhadra and Others (1981) using summated ratings, ascertained the attitude of 397 students towards alcohol concerning health, welfare and morality; attitudes of users were markedly more favorable than of the non-users. Apart from these, many other available studies tangentially deal with attitudes towards drug and drug users in a
similar trend (Krishna, 1980; Muttage, 1981). Mohan (1976) reported that “to satisfy curiosity', rebellion against authority’, and the like were the main reasons (see also Veeraraghvan, 1981). Dube and others (1978) provided a long list of reasons for drug as reported by the subjects. They ranked these as: “to relieve tension, to have fun, to feel good or get high, to satisfy curiosity, to ease depression, to get acceptance in the group, to heighten sexual experience”- and many more. Mendiratta and others (1978) reported six reasons for starting on drugs: curiosity, influence of the companionship, personal problems, one ness in the religious group, physical prowess and substitution of other addiction. Likewise, Ahuja (1978) grouped reasons for drug use among college and university students into four reasons (a) psychological causes such as releasing tension, satisfying curiosity and intensifying perception, etc., (b) physical causes, such as staying awake, heightening sexual experience, etc., (c) social causes like facilitating social interaction, challenging social values etc., and (d) miscellaneous causes such as improving concentration in study, sharpening religious insight and depending self-understanding etc. Many researchers, however, emphasized that these reasons would vary from drug to drug. For example, Khan(1978) reported that in relation to alcohol, the main reasons for its use were celebrating an occasion, feeling good or high and relieving tension, in reverse order, for barbiturates, easing
depression appeared to be the most important; and celebrating occasions or festivals, stood out in relation to cannabis drugs. Many students reported, used opium to heighten or prolong sexual experience, analgesic and tranquilizers to relieve tension and tobacco for relaxation or self-assertion.

Implication of Drug Abuse

Over a long period many hypothesis and theories have been put forwarded with respect to what drugs do or can do. Physical, psychological and social gains or harms of the various grudges have often been recounted; some of them, in passing, have been alluded to earlier. Reality is that all drugs have multiple effects and these vary from dose level to dose level, from individual to individual, from time to time and from setting to setting in the same individual. Needless to say that individual varies in many ways, in weight, age, sex, sickness and health. They vary in the way in which they react to their perception of physiological and psychological in their physical and social environment. The meaning and significance of these perceptions for personal and social adjustment varies. All are influential in determining the response to any drug. Considering these facts in view, physical, social, psychological and economic implications of the drug abuse can be discussed. Drugs have been most extensively studied probably because of the use of drugs may result in acute and severe physical effects like
bronchitis (Chopra and Chopra, 1957; Benabud, 1957), tuberculosis and even premature deaths (Chopra and Chopra, 1957). The main causes of premature death is overdose, but there is a multiplicity of other causes, such as anaphylactic shock, sepsis etc. There is also an excess morbidity from liver disease, infections, including aids, and neurological conditions opiate dependence, especially heroin dependence is also associated with stillbirth, fatal growth retardation, and neonatal morbidity (Gossop and Grant, 1990). They further reported that excess mortality from the use of depressant drugs is mainly the consequence of suicidal or accidental overdose. During withdrawal syndrome, cerebral convulsion and even fatal status epilepsy can occur. Research studies dealing with drugs and cognitive functioning can be divided into three categories. Research conducted upon

(a) Chronic and advanced cases of alcoholism and drug addiction

(b) Subjective with moderate habitual drug usage, after administering particular drugs, and

(c) Subjects with habitual moderate drug use.

Studies dealing with habitual moderate drug use in the absence of drug intoxication indicate impairment in cognitive functions – memory and recall (Aggarwal et. al. 1976); and object reorganization tasks (Monty, et al. 1975) perception,
disorders in the sense of time (Socief, 1967), ability to concentrate and learn (Melson, 1969) and forming judgments (Gaskitt, 1945). Lopez and Manual reviewing literature on the use of narcotic drugs have concluded that there is a broad agreement among the researches that prolonged use of drugs impairs the cognitive functioning.

Studies dealing with drugs and personality variables have found drug addicts to be immature and inadequate having psychopathic traits, depression, tension, high anxiety, and insecurity (Gilbert and Lombardi, 1967. White and Watt (1973) stated that the people who use drugs are bored, tense, insecure, sexually inhibited, confused and worried.

The existing literature on the relationship between drug use and academic achievement among students presents an unclear picture. One the one hand, many studies generally show that drug users are “under achievers” in academic pursuit or are “educational drop-outs”. On the other hand, Buckman (1971) reported LSD users as belonging to the higher achievement group. Ray and Others (1978) found that user and non-user groups similar in terms of their scores on test of attention, concentration and vasomotor co-ordination. However, Khan (1978) found more non-users among the under achievers and more regular to and habitual users among the achievers.

The social implication of drug abuse are less well quantified and documented than the health consequences, but
represent an equally serious problem. The social impact of the personality changes produced by drugs may affect not only the abusers themselves but also those around them and the community where substance use is common, this may have a serious effect on the overall development and economy of the community. The addict may fail to meet important obligations to his family and friends and business associates. His erratic and impulsive behavior and aggressive feeling may cause difficulty in interpersonal adjustment, disrupts harmony in home. Depression and suicidal behavior in the spouse and battered children are more common in the families of drug. The individual may have also legal difficulties because of complications of intoxicated state or criminal behavior such as road theft, forgery etc. To obtain money, to purchase the substance. Besides this, a longer term problem for society is the trans generational deviance that may affect children of drug abusers.

Ramehandran (1978) found social problems in association with drug abuse in five areas:

(A) Road and industrial accidents
(B) Absenteeism and impairment in work efficiency
(C) Disharmony at home
(D) Poor child care, and
(E) Criminal behavior
Moreover, cost of treatment of overdose and other emergencies due to drug taking, cost of treatment of drug dependents and their rehabilitation, cost of treatment of injuries and fracture resulting from drug abuse, loss due to foregone production due to absenteeism, hospitalization and premature death, and loss of foregone production due to time spend in drug trafficking and criminal activities create a tremendous burden on the individual, community even on the country at large.

It is the common observation that among those who come into conflict with the law, many are drug users when hard pressed, a drug user would do anything commit theft, burglary or prostitution to get money in order to procure drugs. Does it imply that drug use per se causes criminal tendency or behavior? Many researchers observed that narcotics led to verities of heinous offences. There are many who report a direct connection between juvenile delinquency and the use of amphetamines and heroin. Anumonye (1980) observed deviant tendencies among young patients treated for cannabis dependence in Lagos. Wolfgang’s (1958) study of homicide committed in Philadelphia in 1949-52 was composed of 588 victims and 621 offenders. He reported that “Either or both the victims and offenders had been drinking immediately prior to the slaying in nearly two-thirds of the cases”. Likewise, Blumberg (1976) reported that between 40-50 % of the patients
was received a long term prescription for narcotics from the London Drug Dependence Treatment Centers had convictions.

In contrast there are a number of researchers who have turned up with differing evidences. There are many who strike a note of divergence. “Addicts are so often criminal”, observed Kolb (1925) in the sense that their actions are harmful to others and criminals behave is criminal ways because they are so disposed, rather than because they take drugs”. This was the similar conclusion of the Indian Hemp Drug Commission 1994; the moderate use of canabies produce no moral injury whatever. In relation to opium, Lindesmith (1965) was emphatic on the independence of the habit from the criminal productivities. Scott and Wilcox (1965) studied delinquents and among them users and non-users of amphetamines. They found no significant differences in delinquency rates. Similarly, Chopra and Chopra (1965) found no marked differences between addicts and non-addicts in terms of criminal propensity.

However, Kodandarum and Murthy (1979) found that the level of drug use was markedly high among habitual offenders. Regarding the nature of antisocial tendencies, type and extent of drug abused show varied patterns. Heavy opiate users commit crimes significantly more frequently than do moderate opiate users. Poly-drug use (including cannabis) is more related to theft and delinquency. Alcohol use is related to fraud. Crime and opiate use tend to influence each other. Craig and Olson (1990)
compared cocaine users and heroin addicts to show more traits of the antisocial personality style, whereas opiate addicts evinced more problems with anxiety and somatic distress. In fact both crime and drug dependence are complex phenomena and the linkage between the two for its elimination require specific data collected under controlled condition. It is also believed that the use of licit or illicit drug is above all a symptom of various problems. People who use drugs are bored, tense, alienated, unsecured, sexually inhibited, confused and worried (White and Watt, 1973). Both alcohol addicts and other drug addicts are often lost, astray, fantasizing, intolerant of frustration, narcissistic, hostile and low in self esteem.

To recapitulate, both developed and developing countries almost equally share the problem of drug addiction. However, its extent and form vary from country to country. What is more alarming, its use among the adolescents and college youth (Khan and Krishna, 1982) is reportedly on the increase. Economic loss cost by drug addiction is the developed and developing societies is substantial. Indirect and invisible losses resulting from addiction far exceed the income derived from the taxes on its products. Reasons of drug addiction are many and varied.
Rehabilitation of Drug-abuser

Drug addiction is a serious and complicated health condition that requires both physiological and psychological treatment and support. Success in becoming drug free is best achieved through formal programs in conjunction with community based support programs offered by many NGOs in different cities, such as Saran, Sahara, Vishwas and Navjiyoti in Delhi. There is also a drug de-addiction centre and many other NGOs at Ghaziabad to provide such treatment. There are many other NGOs initiative in Mumbai, Calcutta, Chennai, Bangalore and Shillong. These centers offer a residential drug substitution program (such as Brupenorphine or Methadone substitution). These treatment programs usually monitor and address the withdrawal symptoms or behaviors, such as, severe pain. They also include psychotherapeutic treatments for the victim (and perhaps family) and in-group settings; have a prolonged after-care component; and facilitate peer support. You may find some of these drug rehabilitation centers in your city that offers this kind of service and support.

However, the parents can help more through early education about drugs, open communication good role modeling and early recognition, if problems are developing. If there is any suspicion that there is a problem, parents must find the most appropriate intervention for their child. The decision to get
treatment for adolescent is serious. Parents are encouraged to seek consultation from mental health professional when making decision about substance abuse treatment for adolescents. Parents and families must be informed consumers and should be involved in their child’s recovery. Here are some important things to consider:

*No single treatment is appropriate for all teens:* It is important to match treatment settings, interventions and services to each individual particular problems and needs. This is critical to his or her ultimate success in returning to healthy functioning in the family, school and society.

*Effective treatment must attend to the multiple needs or the individual – not just the drug use:* Any associated medical, psychological, social and cognitive problem must be addressed.

*Remaining in treatment for adequate period of time is critical for treatment effectiveness and positive change:* Each person is different and the amount of time in treatment will depend on his or her problems and needs. Research shows that for most individuals, the beginning of improvement begins at about three months in to treatments. After this time, their usually further progress towards recovery. Length of stay in a
strongly indicated precursor to effective drug addiction treatment.

_Treatment does not need to be voluntary to be effective:_ Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, school setting or juvenile justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

_Recovery from addiction can be a long term process and frequently requires multiple episodes of treatment:_ As with other chronic illness, relapses to drug abuse can occur during or after successful treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence. Parents should ask what after care treatment services are available for continued or future treatment.

On the basis of existing literature and his keen observation, (Ray, 1983) have suggested the following points to control the drug abuse:

1. To make availability of drugs difficult.
2. To provide knowledge of negative effects of drug to teens.
3. To prescribe methadone (for reducing opiate dependence) and antabuse for alcoholics for vomiting etc.

4. To train them to face anxiety, tension and everyday problems.

5. To establish rapport with drug user and to develop insight among them.


1. Hospitalization is the better way to treat,

2. The patient should be treated by structured and directive program and

3. There should a treatment program, in which, follow-up care must be included.