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Drug Abuse and Drug Addiction

"Say no to drugs" This is the message which is now being relayed by every man of importance to the deluded youth of India. Has drug abuse really become such a social problem in our country ?

Aberrant Behaviour

Drug abuse may be perceived both as aberrant behaviour and as a social problem. In the former sense, it is regarded as an evidence of individual's social maladjustment; in the latter sense, it is viewed as a widespread condition that has harmful consequences for society. In several western countries, drug abuse was regarded as an important social problem since long but in India, it is only since last few years that it has come to be considered a crucial social problem. It is said that India has become not only an important transit centre for drugs (from where drugs are smuggled from some countries and sent to other countries), but the prevalence of drug use is also alarmingly increasing. According to one estimate India has seven lakh heroin addicts alone. India's drug lords' monthly sale in the domestic and international markets varies between Rs. 90 crore and Rs. 100 crore. Likewise, the quantity of illicit drugs seized between 1984 and 1990 has increased over 1,000%. The use of illicit drugs today is not confined to the street urchins and the lower classes; more and more middle and upper class youth are succumbing to drugs.

In spite of this increase, drug abuse in India is still considered more as an aberrant behaviour than an anti-social or a non-conforming behaviour. By this one means that the aberrant person conceals his

transgression from social norms of society, violates norms without questioning their legitimacy, and attempts to escape the penalties for violating norms without proposing changes in them. The aberrant person is believed to be out to satisfy his private interests.

Merton (1979 : 829-32) has distinguished between 'aberrant' and 'non-conforming' behaviour to show the significance of various kinds of norm violations. The 'non-conformist' challenges the legitimacy of the norms (goals and/or means) and he publicly rejects and advocates the substitution of new norms, but the 'aberrant person' neither questions the legitimacy of norms nor seeks replacement of old norms with new norms. No wonder, sociologists perceive drug abuse in India as aberrant behaviour, and drug-users and addicts as aberrant persons, who unlike non-conformists, are not interested in improving social conditions or benefiting mankind.

Several researches have been conducted on drug abuse in India in the last one and a half decade but these studies are more by medical scientists and psychiatrists than by sociologists. This author conducted two studies on drug abuse among college/university students in 1976 and 1986 in Rajasthan to analyse not only the problem of extent of drug abuse but also to study its causes and suggest measures for controlling it. Before examining the findings of my own and other researches, let us first try to understand the basic concepts in drug abuse terminology.

Basic Concepts

The concepts of drug, drug abuse, drug dependence, drug addiction, and abstinence syndrome need some clarity. *Drug* is a chemical substance associated with distinct physical and/or psychological effects. It alters a person's normal bodily processes or functions. But this definition is too broad. In medical sense, a drug is any substance prescribed by a physician or manufactured expressly for the purpose of treating and preventing disease and ailment by its chemical nature and its effect on the structure and functions of a living organism. In the psychological and sociological contexts, drug is a term for habit forming substance which directly affects the brain or nervous system. More precisely, it refers to "any chemical substance which affects bodily function, mood, perception, or consciousness which has potential for misuse, and which may be harmful to the individual or the society" (Joseph Julian, 1977). In terms of this definition, the frequent use of drug is considered so dangerous and sometimes immoral and anti-social, that it arouses a variety of indignant and hostile sentiments

on the part of general public. Some drugs are, however, relatively innocuous and are not addictive or accompanied by harmful physiological effects. The use of such drugs stands in marked contrast to the use of illegal drugs like heroin, cocaine and LSD or the consumption of legal drugs like alcohol, tobacco, barbiturates, and amphetamines, all of which are associated with distinctly harmful physical effects on the person engaged in them.

Drug abuse is the use of illicit drug or misuse of legitimate drug resulting into physical or psychological harm. It includes smoking *ganja* or *hashish*, taking heroin or cocaine or LSD, injecting morphine, drinking alcohol, and so forth. These are sometimes referred to as being 'high on speed' or 'trip' or 'getting kicks'.

Drug dependence denotes any habitful or frequent use of a drug. The 'dependence' can either be physical or psychological. Physical dependence occurs with the repeated use of the drug when the body has adjusted to the presence of a drug and will suffer pain, discomfort or illness if the use of the drug is discontinued.

The word *addiction* is generally used to describe physical dependence. Thus, 'addiction' or 'physical dependence' is "a state whereby the body requires continued administration of the drug in order to function". Body functioning is interfered with if the drug is withdrawn, and withdrawal symptoms appear in a pattern specific for the drug. The total reaction to deprivation is known as *abstinence syndrome*.

The chronic drug user develops a feeling that he must constantly increase the dose in order to produce the same effect as that from the initial dose. This phenomenon is called *tolerance*. It represents the body's ability to adopt to the presence of a foreign substance. However, tolerance does not develop for all drugs or in all individuals ; though with certain drugs (for example morphine), addicts have been known to build up great tolerance very quickly. *Cross tolerance* refers to the fact that tolerance-development for one drug may also result in tolerance for similar drugs.

Psychological dependence occurs when an individual comes to rely on a drug for the feeling of well-being it produces. The word *habituation* is sometimes used to refer to psychic or psychological dependence. The difference between 'habituation' and 'addiction' is that habit is not compulsive as addiction is. Addiction to a drug means that the body becomes so dependent to the toxic effects of the drug that one just cannot do without it.

The *characteristics* of drug addiction are: (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (2) a tendency to increase the dose ; (3) a psychological and generally a physical dependence on the effects of the drugs ; and (4) an effect detrimental to the individual and to the society.

Nature and Impact of Abusable Drugs

The abusable drugs may be divided into six categories: alcohol, sedatives, stimulants, narcotics, hallucinogens, and nicotine. *Alcohol* is used by some people as a normal, pleasant and sociable activity, while others take it as a spur which enables them to work. It also acts as a sedative which calms down nerves or a kind of an anaesthetic which reduces the pain of living. Alcohol relieves tension and lessens aggressive inhibitions. It also impairs judgement and creates confusion.

Sedatives or *depressants* relax the central nervous system, induce sleep and provide a calming effect. Tranquilisers and barbiturates fall into this category. Medically, these are used in high blood pressure, insomnia, epilepsy and to relax patients before and during surgery. As depressants, they depress actions of nerves and muscles. In small quantities, they slow down breathing and heart-beating and make the user relaxed; but in higher doses, their effects resemble alcohol intoxication in which the user becomes sluggish, gloomy and sometimes irritable and quarrelsome. His ability to think, concentrate, and work is impaired and his emotional control is weakened.

Stimulants activate the central nervous system and relieve tensions, treat mild depression, induce insomnia (keep a person awake), increase alertness, counteract fatigue and expressive drowsiness, and lessen aggressive inhibitions. The most widely known stimulants are amphetamines (popularly called 'pep-pills)' caffeine and cocaine Moderate doses of amphetamine, when properly prescribed by a doctor, can check fatigue and produce feelings of alertness, self-confidence and well being. Heavier doses cause extreme nervousness, irritability, headache, sweating, diarrhea, and unclear speech

The stimulant drugs are usually taken orally, though some (like methedrine) are taken by intravenous injection. These drugs do not produce physical dependence, though they are psychologically addicting. Long-term heavy use of the amphetamines causes varying degrees of intellectual, emotional, social and economic deterioration. Abruptly withdrawing the drug can result in mental illness and a deep suicidal depression.

Narcotics, like sedatives, produce a depressant effect on the central nervous system. They produce feelings of pleasure, strength, and superiority, reduce hunger, lessen inhibitions, and increase suggestibility. Included in this category are opium, marijuana, heroin (smack), morphine, pethindine, cocaine (all opiates) and cannabis, (*charas*, *ganja*, and *bhang*) Heroin is a white powder made from morphine; cocaine is made from the leaves of the coca bush and is odourless, cannabis is obtained from the hemp plant ; and marijuana is a particular form of cannabis. Heroin, morphine, pethidine and cocaine are used either by inhaling (the powder), or injecting the liquified form. Opium and marijuana may be smoked, sniffed or ingested.

The withdrawal symptoms vary with the degree of physical dependence. The symptoms, after eight to 12 hours after the last dose, are shaking, sweating, chills, diarrhea, nausea, mental anguish, and abdominal and leg cramps. Thereafter, symptoms increase in intensity, reach a peak between 36 to 72 hours, and then gradually diminish over the next five to 10 days. However, weakness, insomnia, nervousness and muscle pain may persist for several weeks.

Hallucinogens produce distortions of perception (seeing or hearing things in a different way than they actually are) and dream-images. Their use is not advised by medical practitioners. The well-known drug in this group is LSD, which is man-made chemical. It is so powerful that one ounce produces three lakh human doses. An amount literally smaller than a grain of salt can produce gross psychotic reactions in human beings LSD may be obtained as a small white pill, as a crystalline powder in capsules, or in liquid in ampules. Usually, LSD is taken orally but it may be injected. The effect of an average dose of LSD usually lasts from eight to 10 hours. Panic, depression and permanent severe mental derangement can result from an attempt to withdraw from its use.

Nicotine includes cigarettes, *bidi*, cigars, snuffs and tobacco. Nicotine has no medical use. The risk of physical dependence, however, may be there. It leads to relaxation, stimulates central nervous system, increases wakefulness and removes boredom. But the frequent or the heavy use of nicotine may cause heart attack, lung cancer, and bronchitis. The law does not classify this as a drug.

Stimulants, depressants, narcotics and hallucinogens are also called psychoactive drugs.

Extent and Nature of Drug Abuse

How widespread is the use of illegal drugs and the misuse of legal drugs in our country ? Empirical studies of three different sections of population conducted in India indicate the extent of its prevalence. These studies are : (1) study of college/university and high school students, (2) study of industrial workers, and (3) study of people in rural areas.

Study of College/University Students

The studies on drug abuse among college/university students may be classified as (a) *single studies*, (b) *joint studies*, and (c) *multi-centred* studies. Single studies have been conducted by scholars like Banerjee (in Calcutta in 1963), Dayal (in Delhi in 1972), Chitnis (in Bombay in 1974) and Varma (in Punjab in 1977). Joint studies have been conducted by Sethi and Manchanda (in U.P. in 1978), and by Dube, Kumar, and Gupta (in 1969 and 1977). Multi-centred studies were conducted in 1976 (in seven cities) and in 1986 (in nine cities) and both were coordinated by D. Mohan of the AIIMS, Delhi. If we take all the studies on college/university students together, we find that the prevalence rate of drug abuse varies from 17.0% to 25.0% in different cities. But excluding alcohol, cigarettes and painkillers, the extent of drug consumption is only 4.0% to 6.0% Other important findings of these studies are: (1) Drug consumption differs with respect to professional and non-professional courses. When Sethi and Manchanda found that medical students were using more drugs than non-medical students, my own study in Jaipur (both in 1976 and 1986) indicated that drug abuse among medical students is not high In the 1976 study, I found the highest use of drugs among law students (26.1%) followed by commerce (23.6%), arts and social sciences (17.5%), medical (14.0%), science (13.6%), and engineering (4.6%) students. In the 1986 study, however, the highest use was found among commerce students (31.0%) followed by arts and social sciences (27.2%), science (20.3%), medical (7.3%), engineering (6.0%) and law students (4.8%) (2) Of the current users, about 90.0% are *experimenters* (who take drugs once a week or less often), 9.0% are *regulars* (who take drugs several times a week), and only 1.0% are *addicts* (who cannot live without drugs). (3) About 75.0% students use only alcohol and/or tobacco, about 15.0% take one or the other drug along with alcohol and/or tobacco, and only 6.0% to 10.0% take drugs other than alcohol and/or tobacco. (4) In

terms of nature of drugs used, if we exclude alcohol and cigarettes, about 20.0% use pain-killers, 35.0% use narcotics (heroin, cocaine, cannabis, etc.) 5.0% to 7.0% use stimulants, and less than 1.0% use hallucinogens (LSD). Thus, a little more than three fourths of the drug users take only *recreational drugs*, that is, for relaxation and fun, one-fifths take *medically prescribed* drugs to alleviate physical ills, and only about 2.0% to 3.0% take *drugs of abuse* to escape from reality. Since 'down' drugs are more popular than 'up' drugs, it could be inferred that the youth wish to go to sleep rather than 'wake up'. (5) The background of the users, is as follows: (a) undergraduates use drugs as much as the postgraduates, (b) education in public schools increases the use of drugs among students; particularly among girls, (c) educational institutions with hostels attached to them produce more drug users than those without hostels, (d) academic frustration is not the important cause of drug use, that is, high or low division in examination does not affect the incidence of drug usage, (e) there is a relationship between drug use and lack of interest in co-curricular and extra-curricular activities, (f) the affluent youth getting a higher amount of pocket money from their parents tend to experiment with drugs more than the youth from the lower income groups, (g) though incidence of drug abuse is found more among students with an urban background than those with a rural one, it cannot be hypothesized that urban upbringing is an important cause of drug use, and (h) drug-using deviant behaviour attracts students irrespective of religion, caste or language background

Taking all the characteristics of the drug users together, some high-risk categories in drug usage can be identified. These are : high income groups, age group of 16-21 years, public schools and hostel attached institutions

The researches also indicate that about 60.0% students take to drugs on the suggestion of friends, 5.0% on the suggestion of some family member or kin, 10.0% on the suggestion of physicians, and 25.0% of their own accord. Thus, on the basis of the 'initiative' factor, a large number of drug users may be identified as *submissive*, a small number as *self-directive*, and a few as *adaptive*.

Researches on High School Students

Two important studies on drug abuse among school children are by Mohan, Sundaram and Chawla conducted in Delhi in 1978, and by Rastogi conducted in 1979. Five years ago (1986), one more study was

conducted on high school students in four metropolitan cities of Delhi, Bombay, Calcutta and Madras by Mohan, Pradhan, Chakrabarthy, and Ramchandran but its analysis is yet to be published. Mohan's study of about 2,000 high school students in 1978 revealed that though 63.0% students were using drugs, a very large number of them took pain-killers, smoked cigarettes or consumed alcohol. Only 0.2% to 0.4% took sedatives, stimulants and narcotic drugs. This shows that drug abuse among high school students is very limited.

Researches on Industrial Workers

Gangrade and Gupta studied 4,000 industrial workers in 1970s in Delhi and found that the rate of drug prevalence was only 10.4% which in comparison to college students is very low. They also found that : (a) most of the users had started using drugs without medical prescriptions; (b) a majority of the users were in their 20s or early 30s ; (c) four-fifth workers had started using drugs after they had started working as workers; (d) two-thirds were introduced to drugs by friends or co-workers; and (e) sub-cultural background, high income, low level of education, and pressure of peer groups are the important factors that lead to drug use among industrial workers.

As regards the nature of drugs used, Gangrade found that alcohol was used by 95.0% of the sample studied, (or by 10.0% of the total workers' population), *charas* by 18.0%, *bhang* by 8 0%, *ganja* by 7.0%, and opium by 2.0%. A worker spent about Rs. 40 a month on drugs.

Researches in Rural Areas

The first research on drug abuse among people in rural areas was conducted in 1971 by Elnagar, Maitra, and Rao in a village in West Bengal, and then in 1972 by Dube and in the same year by Verghese and Beig. They found addiction to alcohol only in 1.0% to 2.0% of the cases. However, four studies conducted between 1974 and 1979 give a better picture of drug abuse in rural areas. Deb and Jindal's study conducted in 1974 in Punjab villages found alcohol abuse in 74.0% of the adults above 15 years. Gurmeet Singh's study conducted in 1978 in selected villages of Punjab found drug abuse in 29.0% cases (of 10 and above years age), tobacco use in 40.0% cases, alcohol use in 26 0% cases, opium use in 19 0% cases, and cannabis use in 20 0% cases Sethi and Trivedi's study conducted in 1979 in eight villages covering a

population of about 2,000 persons (above ten years of age) found the prevalence rate of 25.0%. They found addiction in 6.0% cases, alcohol consumption in 82.0% cases, cannabis consumption in 16.0% cases, and opium consumption in 11 0% cases Lastly, Mohan, Prabhakar and Sharma's study conducted in 1977 in six blocks in three border districts of Amritsar, Ferozpur and Gurdaspur in Punjab covered 1,276 households and a total population of 3,600 persons above 15 years age. Mohan's main findings were· (i) 18.0% households studied had no drug user, 60 0% had one user, 16.0% had two users and 6 0% had three or more users; (ii) the most commonly abused drug by males was alcohol (50 0%) followed by tobacco (19 0%), opium (6.0%), and cannabis (1 0%) Among (married) females (above 15 years of age), tobacco was used by 4 0%, alcohol by 1 0%, pain-killers by 1.0%, tranquilisers, by 0 5%, and opium by 0.5%. It can, thus, be suggested that drug abuse in rural areas is predominantly a masculine activity.

If we take all the four studies of Deb, Gurmeet Singh, Sethi and Mohan together, they point out that among the people in rural areas, the use of alcohol is very high followed by tobacco and opium, while the use of cannabis is only 1 0% to 2.0%

If we take all the studies (pertaining to college/high school students, industrial workers, and rural people) together, we find that upto 1980, the use of drugs was not high However, after 1980, the availability of heroin in our country has so increased that consumption of smack and other illegal drugs has increased among students, slum dwellers, truck-drivers, rickshaw-pullers and industrial workers. Even when these addicts are detoxified, that is, relieved of their dependence on drugs, 90 out of the 100 cannot 'kick' their habit, and they continue their petty crimes to support a very expensive addiction Today, five drug deaths occur in Bombay every day ; each night more than 100 teenagers take to drugs in the country

A UN survey report compiled by the International Narcotics Control Board released in the second week of January, 1991 has pointed out that in 1990 drug abuse lessened in some developed countries but grew in parts of the Third World. The study found (*Hindustan Times*, 11 January, 1991) that the number of Soviet drug abusers, mostly of cannabis, almost doubled over the past five years, to reach an estimated 1,40,000. In Europe, the use of crack remained negligible but the use of cocaine increased. In North America and in Canada, cannabis and cocaine remained the drugs of choice. Drug abuse alarmingly increased among women between the ages of 18 and

29. In the United States, the social and economic cost of drug abuse was estimated in 1990 at 60 billion dollars annually. However, there was an apparent lessening in the use of crack and cocaine manifest in the drop in attributable deaths and hospital admissions. In Africa, drug abuse has spread to the entire continent over the past few years. Much of it is the use of heroin and cocaine. In South America, the easy availability of drug (heroin) led to its greater abuse. In East and South East Asia, illicit opium production doubled in 1988-89 from the previous year to about 2,000 tonnes and remained at the same high level in 1990-91. In China, heroin abuse in Southern border areas was spreading to other parts of China. In Japan, cocaine seizures increased five fold. In Malaysia, heroin was most abused, with an estimated one lakh addicts. In Bangkok, large-scale heroin abuse was compounded by the associated rapid spread of AIDS, but the number of newly registered abusers has been decreasing. In Australia, the estimated number of heroin addicts is between 90,000 to 1,30,000. In South Asia, in Bangladesh, drug abuse rose with an estimated 50,000 users alone in Dhaka, the capital. In India, drug abuse rose in major cities.

It may be pointed out that by and large those persons are predisposed to drug usage who (1) have difficulties in assuming a masculine role; (2) who are frequently overcome by a sense of futility, expectations of failure, and general depression; (3) who are easily frustrated and made anxious; and (4) who find frustrations and anxieties intolerable.

Motivations in Drug Usage

What are the causes of drug abuse ? The causes may be classified under four heads : (1) *psychological* causes, like relieving tension, easing depression, removing inhibitions, satisfying curiosity, removing boredom, getting kicks, feeling high and confident, and intensifying perception, (2) *social* causes, like facilitating social experiences, being accepted by friends, and challenging social values, (3) *physiological* causes, like staying awake, heightening sexual experiences, removing pain, and getting sleep, and (4) *miscellaneous* causes, like improving study, sharpening religious insight, deepening self-understanding, and solving personal problems, etc.

My study (of 4,081 college/university students) revealed that of the 1,469 students who consumed drugs, 85.5% took drugs because of psychological reasons, 15.2% because of physiological reasons, 10.9% because of social reasons, and 28.4% because of miscellaneous reasons.

The detailed analysis pointed out that : (1) the largest number of drug-using students comprised individuals who were devoted to pleasure, seeking new excitement and sensation, (2) a small number took drugs as an escape mechanism or to alleviate distress, and (3) a very small number of students receiving drugs in the course of medical treatment for the relief of pain continued to take them long after the treatment was over.

This enables us to question the view held by the psychiatrists that drug users exhibit a personality type involving strong dependency needs with pronounced feelings of inadequacy. It will not be out of place here to point out that Alfred Lindesmith (1940 : 120) too has provided a detailed critique of the theory of 'psychopathic personality' or 'psychopathic predisposition'.

My view is that drug abuse is a *learned* behaviour which is learnt by individuals in interaction with peers, acquaintances, family members and others in three ways : through persuasion, through unconscious imitation and through reflective thinking. In the analysis of the sources of getting drugs, it was found that (1) drugs were generally obtained from the non-medical sources (friends, acquaintances, family members, home cupboard), (2) medical sources were used more by girls than by boys, and (3) the non-medical source mentioned most often was 'friend'.

Like analysing causes of drug abuse, it is equally essential to analyse the causes of abstinence, that is, why the non-users abstained from taking drugs or the 'past-users' discontinued them. My study of students showed that the important causes of abstinence and discontinuation were. personal (49 3%), physiological (23.8%), social (22.4%), religious (22.3%), and economic (4.1%). The personal causes were: lack of interest/curiosity, personal dislike or hatred for the use of drugs, and non-availability or non-accessibility to drugs; the physiological causes were: risk of physical/mental dangers or deteriorating health, risk of dependence on the drug, and having a bad experience of 'being on a trip'; the social causes were: pressure of friends, influence of parents, risk of social disapproval; the religious cause was the moral principles; and the economic cause was that individual had either no money to purchase drugs or found drugs too expensive.

Role of Family and Peer Group in Drug Abuse

Family and peer group associations are the primary potent influences upon the direction which individual takes and maintains in his life. One

hypothesis in my own study of drug abuse among college/university students was that drug usage is influenced by the quality of *affectionate family relationships*. This term (affectionate family relationship) was operationalised on the following bases : (1) parents take an interest in the career of their children and are conscious of their parental obligations, (2) relations between parents of drug users, between drug users and their parents and between users and their siblings are based on harmony and solidarity, (3) parental control is neither very harsh nor very lenient so as to give an opportunity to the child for self-expression, (4) the size of family is so manageable in terms of family income that no child in the family suffers from an unfulfilment of the necessities of life, (5) parents broadly conform to social and moral norms setting examples for their children to follow, and (6) the child exhibits a feeling of trust and security in the parents by taking them into confidence and by seeking their advice and help in facing perplexing problems.

The study revealed that in a good number of cases, the families of drug-users were not 'normal' and family relationships were not 'affectionate'. In testing the relationship between drug usage and 'staying away from parents', it was found that residence with parents was as important in the incidence of drug usage as residence in hostel. In other words, family background is significant in drug usage. The nature of family control, the discipline imposed by the parents over the children, the parents' interest in their friends, leisure activities and their future career prospects and parents remaining conscious of their obligations towards their children were found to be important factors which determine the children's inclination to step into the world of drugs. The drinking/smoking and drug taking behaviour of family members also had a bearing on use of drugs It may therefore, be maintained that family environment is an important factor in drug usage.

Like the family, peer group pressure was also found influential in drug usage. About 81.0% drug users had friends who were drug-users. Another 44.0% drug users were initiated into drug use by their friends. Approximately 31.0% drug users always took drugs in the company of their friends. As many as 63.0% drug users got first knowledge of drugs from their friends. And, 17.0% users had first taken drugs in their friends' house. All this shows that peer group culture has a significant effect on the drug use behaviour.

On the basis of the above analysis, it may be pointed out that the main causes of drug abuse are: family environment, mental condition, social factors like oppressive social system and power structure, subcultures (slum areas, college/hostel subcultures, etc.), peer pressures, personality factors (dependent personality), and pursuit of pleasure and fun.

Theories of Causation

The theoretical explanations of drug use may be grouped broadly under four heads: physiological, psychological, socio-psychological and sociological.

According to the *Physiological Theory*, people take drugs because of physiological aberrations and deficiencies or due to bodily adaptation to chemical properties of the drug. Mordones, Silkworth, Randolph and Nimwich, are the scholars who have explained drug use in terms of chemical reactions. But this theory, though widely accepted in the 1910s and 1920s, has been found inadequate ever since the psychological and sociological attributes of people who use drugs have been pointed out by the empirical studies.

The psychologists have explained drug use and drug dependence mainly in terms of Reinforcement Theory, Personality Theory, Power Theory, and the Weakened-Self Theory. In the *Reinforcement Theory*, Abraham Wilker (Strak Rodney : 1975, 102) has maintained that the pleasurable sensations produced by drugs reinforce their use. The *Personality Theory* has explained drug use in terms of satisfying certain psychological needs or compensating for certain psychological shortcomings. It refers to distinctive personality traits associated with drug dependence and emphasizes on 'dependent personality' as the cause of drug dependence. Chein (1969 , 13-30), Knight (1937, 538), and Robert Freed Bales (1962 : 157), the main supporters of this theory, hold that people with dependent personalities require emotional support and attention from others and failure to get it is substituted by drug use. Chein in his study of narcotics in New York city found that persons with personality traits like passivity, low self-esteem, little ability for self-direction, distrust of other people, difficulty in handling frustrations and anxieties, inadequate masculine identification and failure to resolve childhood conflicts, take to drugs. David McClelland (1972) challenging the Personality Theory has propounded *Power Theory* and has explained drug use (alcohol) as an expression of a person's need for power. The light and occasional alcohol user gets a

feeling of enhanced social power while the heavy alcoholic gets a feeling of enhanced personal power. In the *Weakened Self Theory* or *Fear Theory*, Stanton Peele (1975) has maintained that drug addiction is a response to fear and insecurity to the conditions of modern life.

All these psychological theories are incomplete in three ways : (1) they fail to explain how the personality traits, exclusive to drug users, are developed by the users, (2) they fail to explain why this syndrome leads to drugs or alcohol rather than to some other behaviour like suicide, and (3) they failed to identify personality traits exclusive to drug addicts or alcoholics and why people with similar personality profiles do not take to drugs.

In the *Socio-Psychological Labelling Theory*, Howard Becker (1963) and Kai Erickson (1964 : 21) have maintained that a person becomes a drug dependent or an alcoholic under the pressure of being labelled as an addict or an alcoholic. But it fails to explain why people first engage in drug behaviour that gets them socially labelled as deviant addicts.

The *Sociological Theory* holds that it is the circumstances or social environment which make people drug addicts. Sutherland's *Differential Association Theory*, when applied to drug use, explains drug taking as behaviour learned from other persons, principally in small intimate groups. The *Social Learning Theory*, which is the expansion of Differential Association Theory and the Reinforcement Theory, has been propounded by Akers and Burgess. When the Reinforcement Theory merely assumes that drug dependence is conditioned learning, the Social Learning Theory examines the social sources of reinforcers that operate in the learning process. The reinforcement comes from association with persons favourably defining the drug use The *Strain Theory* focuses on the intense pressures put on individuals that cause them to deviate from the internalised norms. According to Merton, the source of this pressure is the discrepancy between goals and means. Those who fail to achieve their goals through legitimate means become so frustrated that they turn to the use of drugs and alcohol Merton calls them 'retreatists'. The *Subcultural Theory* holds that different groups within society are socialised into different sets of norms and deviance is a judgment imposed by an outside group. Thus, what may appear to be deviant behaviour is really conformity to a set of norms espoused by one group but rejected by another. When young people claim adults are hypocritical to ban cannabis in a society where alcohol drinking is socially permissible and when adults denounce cannabis as more dangerous substance than alcohol, two subcultures are fighting over

whose norms shall prevail Thus, drug use is the result of clash in sub-cultural values of the young and the adults

All the above sociological theories have their own perspectives. But each theory leaves a number of questions unanswered. In my own Social Bond Approach (1982 · 120) I have explained drug abuse in terms of weakening of social bond between individual and society due to maladjustment (in status), unattachment (to social groups), and non-commitment (to social roles). It is individual's attachment to others, commitment to his social roles, and adjustment to various situations that determine his values about what is good or desirable, his behaviour patterns and his motives in deviating from the dominant values of the culture. It is only by recognising the role and analysing the nature of these three factors in particular or social bond in general that we will be able to point out the structural or the institutional measures to control drug abuse

Measures to Combat Drug Trafficking, Treat Addicts and Prevent Drug Abuse

Over the last few years, India has been facing the problem of increasing trafficking in drugs, particularly transit traffic in respect of heroin and hashish from the Middle East region destined to western countries. As a result of this transit traffic, metropolitan cities like Bombay, Delhi, Calcutta, and Madras have become vulnerable to drug trafficking. During the year 1988, nearly 3,020 kg of heroin was seized in India which was the highest quantity ever seized by any country. The quantities seized were 10% more than seizures in 1987, 60% more than in 1986, three times more than in 1985, 12 times more than of 1984, and 18 times more than of 1983. Heroin seized in 1989 (2,500 kg) and 1990 (2,000 kg) was less than that seized in 1988. (*India Today*, 15 November, 1991). Opium seized was 2,929 kg in 1987, 3,100 kg in 1988, 4,855 kg in 1989, and, 1,427 kg in 1990. Hashish seized was 14,796 kg in 1987, 17,523 kg in 1988, 8,000 kg in 1989 and 5,000 kg in 1990. Heroin in India is purchased from the local sources at say Rs. 70,000 per kg and the trafficker then sells this to foreigners at the rate of Rs. 3 9 lakh per kg ($ 15,000 per kg). Having received this money in foreign currency, it is used for varied purposes.

The 'profits' generated by drug trafficking are. (i) money is used for financing politicians and developing lobies in bureaucracy, judiciary, police, prisons, and media; (ii) money is invested in shell corporations that take over legitimate business organisations; (iii) money is

laundered in purchasing arms for terrorism; and (iv) intelligence agencies take help of drug traffickers to assist terrorist activity. But the fact is that all these 'profits' are nothing but subversion of democratic processes.

In order to combat trafficking in drugs, among the various measures adopted by the government, one was the enactment of an act in 1985, called The Narcotic Drugs and Psychotropic Substances Act. It came into force on November 14, 1985. It provides for a minimum punishment of ten years rigorous imprisonment and a fine of Rs. 1 lakh which may be extended to 20 years rigorous imprisonment and a fine of Rs. 2 lakh. In respect of repeat offences, the Act provides for a minimum punishment of 15 years rigorous imprisonment extendable upto 30 years and also a minimum fine of Rs. 1.5 lakh which may go upto Rs. 3 lakh. The courts have been empowered to impose fines exceeding these limits for reasons to be recorded in their judgement.

The Act relates to drug addicts too. It lays down imprisonment of one year or fine or both for illegal possession in small quantity for personal consumption of any narcotic drug or psychotropic substance. It also empowers the court to release an addict for undergoing medical treatment for detoxification or de-addiction from a hospital or an institution maintained or recognised by the government. In keeping with this, the Act requires the government to establish as many centres as it thinks fit for identification, treatment, education, after-care, rehabilitation and social reintegration of addicts.

The Ministry of Welfare, Government of India has also evolved a policy for mobilizing voluntary action to create an awareness for the prevention of drug abuse A large number of voluntary organisations are being supported to educate the people about the ill-effects of drug addiction. It also provides funds for the establishment of counselling and de-addiction facilities. The National Institute of Social Defence has been training functionaries of governmental and non-governmental agencies engaged in drug abuse prevention.

Some state governments have also undertaken programmes to impress upon the university authorities to mount a special vigil against drinking and drug abuse in hostels and campuses. In the voluntary sector too, a number of counselling and guidance centres have been established in different cities. These centres are engaged in supplying information regarding the sources of treatment, coordinating with rehabilitation agencies, data collection, dissemination of knowledge, liaison with enforcement agencies and psychological aid by way of individual and group therapy.

Control over Drug Abuse

The control over drug abuse can be made possible by adopting following measures.

(1) *Imparting education about drugs.* The target population for educational measures for prevention should be young college/university students particularly those living in hostels and away from the control of their parents, people living in slums, industrial workers, and truck drivers and rickshaw-pullers. The method of imparting education should be such that people involve themselves actively and there is a free exchange of valuable information. The type of education which would be more effective and misleading knowledge about artificial euphoria and acquire information which is more authoritative pertaining to physical and psychological effects of the so-called mood modifying drugs, their pharmacological properties and their medical uses Parents have to play an important role in imparting education.

(2) *Changing physicians' attitudes.* A change in the attitude of doctors in prescribing too many drugs can go a long way in controlling the abuse of drugs The doctors have to show a greater care in not ignoring the side effects of the drugs Though drugs help many, yet there are dangers of over-dependency. Once a patient gets a prescription from a doctor that cures his ailment, he ceases to consult the doctor and continues to use the drugs indiscriminately or excessively whenever he suffers from the same ailment. Thus, people come to depend more on medication than on physician which ultimately is dangerous

(3) *Undertaking follow-up study* of addicts treated under detoxification programmes.

(4) *Giving deterrent punishment to policemen* and other law-enforcers found working in collusion with drug pedlars.

(5) Parents need to play a crucial role in controlling drug use among their children. Since parental neglect, over-hostility, rejection, marital disharmony play an important role in perpetuating drug addiction, parents have to take more care in keeping the family environment conducive and harmonious Since addiction does not develop overnight and it involves a process of evolution of losing interest in studies, activities and hobbies, indulging in irresponsible behaviour, irritability, impulsive conduct and having a dazed expression, parents can locate the early signs by being alert and can make sure that the child withdraws from the habit.

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