# CHAPTER I

# INTRODUCTION

"Substance abuse" is a relatively new term replacing the conventional phrase "drug abuse". Drugs are substances whose chemical or physical nature alters the structure or function in the living organism (Ray, 1987). Substances may include alcohol, tobacco (licit drugs) and other illicit drugs like cocaine and heroin. Adolescents are more susceptible to abuse these substances. Substance abuse is conceived as a disease. It is a family disease that runs in families. It is a progressive disease in which factors like maturity, stress, boredom, and peer group attractions play a part in the rate of its progression. Several studies establish that addiction has all the characteristics of being a chronic disease in which relapse is all too common. Also the fact that it has the characteristics of being contagious and many a times fatal too (leading to lung cancer, accident etc.).

The "germ" of this disease lies in the family. The addict is no longer viewed as an individual with problematic symptoms, but as belonging to a family with a problem. Much of the research in western countries focuses on family dynamics and adolescent drug use. In the Indian context, there has not yet been much research on these issues. In 1989, Purnima Mane has reported that addiction is viewed as a symptom of pathology in the family. This, in her opinion, is so because the addict is in many cases an adolescent/young adult and parent-child conflict is common at this stage. She stresses that family therapists must view that the family member manifesting the problem (the addict) is the symptom bearer of a family problem and, thus, the focus must shift to involve all family members to bring about needed changes. It may be interesting to refer to "A drug addict's explanation" published in "The Telegraph" on 4.3.93 where-in the anonymous teenager has put the blame squarely on his parents: " My parents, who are constantly fighting among themselves at home have given me everything, except love and understanding. And the only girl I loved, left me in October.... Can they fulfil our wishes? At least when I take the push or puff I dream and feel as if I am in a new world".

Family systems of young substance abusers fall under the broad area of "families and addictions" which focuses on the interplay and reciprocity between the dysfunctional families and addictions. Dysfunctional family includes non-harmonious functioning within the family - for example lack of communication, lack of emotional bonding, child abuse and neglect, parental nagging, defective rules

and roles, lack of family activity together, divorce etc. Various addictions include addictions to substances (alcohol, tobacco, and other drugs), to food (overeating and anorexia nervosa), to compulsive relations (sexual and love addictions) and even to habitual behaviour (workaholism, gambling, compulsive shopping and religious compulsivities). Studies of all these addictions are beyond the scope of this study. The focus, here, is on addictions to substances only.

The reciprocal nature of dysfunctional families and addictions is seen from two aspects. First, dysfunctional families often produce addictions in the family members, which affect the quality of family life. Family therapists, however, see drug abuse as having circular causation. Rather than viewing the drugs, the family, or the child as the cause of problems, they see all these factors as mutually reinforcing. The dysfunctional family, the drug, or the dysfunctional adolescent which comes first is still debatable. Second, this reciprocity leads addictions to pass from one generation to other, unless there is successful intervention.

The study of family system is a new but dominant approach in understanding the families of substance abusers. Within the family system, the subsystems, such as spousal, parent-child, parental (husband and wife relating to each other as parents), and the personal (the individual and his relationships), function. This approach conceptualizes family as a "gestalt" meaning "the whole is more than sum of its parts". The family can be understood fully by examining the whole system, not the individual susbsystem separately.

The major constructs of family systems are families' management practices (disciplines, rules and roles), its emotional bonding or cohesion, communicational patterns etc. Authoritarian parents use excessive shame to control their children. This results in emotional violence when the shame is intrenalized and this gradually leads to addictive behaviour to defend against shame, to cover-up self-hatredness, to deny powerlessness, and to self -medicate away the pain (Bepko & Krestan, 1983; Bradshaw, 1988; Kaufman , 1989). In a dysfunctional chaotic family, substance abuse may increase because of the greater autonomy granted to adolescents. A disharmonious family characterized by high conflict and little cohesion, results in greater alcohol use by parents and adolescents too (Webb & Baer, 1995). Similarly,

for adolescents, problems such as identity issues, substances abuse, eating disorders, running away from home and delinquency, all have been related to problematic interactions in the family of origin (Bagarozzi & Anderson, 1989; Bowen, 1978; Haley, 1980; Stanton & Todd, 1982; Stierlin, 1981).

A study of family history is also an important variable. Drug addiction is viewed as a family disease resulting from some combinations of inherited factors and environmental influences such as modeling and parenting styles. This has support from clinical studies (Glenn & Parsons, 1989; Penich et al., 1987); general population studies (Dawson et al., 1992; Harford, 1992); controlled studies (Chassin et al., 1991, 1993; Sher et al., 1991); and also from community samples (Barnes & Welte, 1990). A genetic approach explains alcoholism as an inherited characteristic passed on from parents to children. The questions are : How is alcoholism transmitted? What is transmitted ? The answer explains different kinds of studies - Family studies, Genetic Marker studies, Twin and Adoptee studies etc. Family studies found that alcoholics are more likely than nonalcoholics to have an alcoholic father, mother, sibling or other relatives (Cotton, 1979) . Genetic marker studies identified brain waves in sons of alcoholics as a biological marker for alcoholism that differ from control subjects. Twin studies reported high concordance rate for alcohol abuse among identical twins than fraternal twins. Finally, Adoption studies found that sons of alcoholics were four times more likely to be alcoholics than the sons of nonalcoholics, whether reared by non-alcoholic foster parents or by their own biological parents. As the majority of the adoptee research has been conducted with males, it is premature to conclude that there is a genetic basis for alcoholism until more research with women has been undertaken.

Research investigating a genetic basis for drug abuse (other than alcohol) is in a formative stage. No twin or adoptee studies have been instituted thus far. In conclusion, the genetic factor may be established in alcoholism. But in drug abuse, factors such as personality, environmental, psychological, and sociocultural processes may exert a greater influence. The ways in which these factors interact, lead to different theories of substance abuse.

## Theories of Adolescent Substance Abuse

Social scientists enquire why adolescents use and abuse substances. Hawkins et al. (1992) identified several pieces in the puzzle of substance use that include - laws and norms favourable towards drug use; availability of drugs; extreme economic deprivation; neighbourhood disorganization; certain psychological characteristics; a family history of alcoholism and parental use of illegal drugs; poor family management practices; family conflict; low bonding of family; academic failure; lack of commitment to school; early peer rejection; social influences to use drugs; alienation and rebelliousness; attitudes favourable to drug use; and early initiation of drug use. Numerous theories explain how and why different constructs are related to substance abuse.

Lettieri et al. (1980) reviewed 43 different theories of substance abuse among which some are similar, some are different, and some are overlapping in nature. Recently, Petraitis et al. (1995) condensing these theories, reviewed 14 multivariate theories which include (a) two theories that focus on cognitive causes of substance abuse, (b) two theories that focus on social learning processes, (c) two theories that describe how weak commitment to conventional values and weak attachment to families affect substance abuse, (d) four theories that stress how intrapersonal characteristics and personality traits of adolescents contribute to substance abuse, and (e) four integrative theories that incorporate cognitive, learning, commitment/attachment, and intrapersonal influences.

### A. Cognitive-Affective Theories

Within the cognitive-affective theories come theory of reasoned action and theory of planned behaviour. Theory of reasoned action focuses on how perceptions about the costs and benefits of a substance use contribute to the adolescent's decision to use or not to use a substance (Ajzen & Fishbein, 1980 ). In theory of planned behaviour, Ajzen (1985, 1988) modified reasoned action theory to include an additional construct "self-efficacy"-the perception of control over the successful completion of a particular behaviour - that affects

behavioural intentions. Two forms of self-efficacy -"use self-efficacy" (where to get the substances and how to use them) and "refusal self-efficacy" (how to resist social pressure to use substances) are important. These two theories raise two concerns. Methodologically it is not clear whether substance-specific beliefs are primarily a cause or a consequence of substance use (Stacy et al., 1994). Theoretically, the theories fail to explain the long-term roots of substance abuse.

**B. Social Learning Theories**

Two theories of social learning processes include social learning theory and social cognitive/learning theory. Social learning theories (Bandura, 1977, 1986) propose that an adolescent's involvement with substance-using role models has three sequential effects -beginning with the observation and imitation of substance-specific behaviour, continuing with the social reinforcement (encouragement and support) for substance use, and culminating in an adolescent's expectation of positive and physiological consequences from future substance use. Social cognitive/learning theory goes beyond the social learning theory by including the concept of self-efficacy. Role models (close friends and parents) shape both the "use self-efficacy" and the "refusal self-efficacy" (Bandura, 1977, 1982, 1986). These theories fail to explain why some adolescents get so involved with role models while others do not.

**C. Conventional Commitment and Social Attachment Theories**

Within this category, Elliot et al.'s (1985, 1989) social control theory and Hawkins and Weis's (1985) social development theory assume that emotional attachment to drug abusing peers is a primary cause of substance abuse. According to social control theory, the causes are (i) strain which includes school strain, occupational strain, and home strain, and (ii) social disorganization which includes both disorganized neighbourhood (where crime and unemployment are common) and disorganized families (broken families). According to social development theory, the causes are (i) lack of opportunities for rewarding interactions at home and school, (ii) inadequate reinforcement from parents and teachers, and (iii) improper socialization. These two theories place

less emphasis on two other influences. First, they deemphasized the role of substance-specific cognitions by arguing that attachment to substance-using peers affects substance use directly. Second, they do not address many of the intrapersonal characteristics (traits, states, and skills).

**D. Intrapersonal Theories**

Four theories - social ecology model, self-derogation theory, multistage social learning model, and family interaction theory, are developed. Kumpfer and Turner's (1990-1991) social ecology model posits that low academic self-efficacy creates school-related stress that makes the adolescent vulnerable to the involvement with deviant peers and substance abuse. Kaplan et al.'s (1982, 1984) self-derogation theory explains that adolescents experience low self-esteem and frequent self-derogation if they repeatedly receive negative evaluations from conventional others and finally involve with drug-abusing peers to use substances. Simons et al.'s (1988) multistage social learning model proposed a three-stage model of substance use. The first stage-initiation to substance use, has three causes- (i) personal value system, (ii) parental warmth, support, supervision, and discipline, and (iii) parental substance use. The second stage - involvement with deviant substance-using peers, is due to deficiency in social skills and initial substance use. The third stage - escalation from initial substance abuse to more regular abuse, is due to when adolescents (i) observe substance use among their parents, (ii) have peers who encourage substance use, (iii) are emotionally distressed, and (iv) have inadequate coping skills. Simons integrates both social learning processes and intrapersonal characteristics of adolescents, their parents, and their peers into a single model of substance use.

No other theory offers such detailed and comprehensive description of substance use. Finally Brook et al. (1990) postulates family interaction theory in which emotional attachment to parents, social learning, and intrapersonal characteristics of adolescents affect substance use. Several longitudinal studies show that adolescents who, as children received higher levels of support and encouragement from their parents, became less involved in substance use than adolescents who received less parental support (Baumrind, 1985;

Brook et al.,1990; Dembo et al., 1990; Johnson & Pandina, 1991; Shedler & Block, 1990; Vicary & Lerner, 1986). The four above intrapersonal theories have two limitations. First, longitudinal studies suggest that intrapersonal characteristics are poor predictors of substance use. Second, these theories deemphasize the role of cognitive processes in substance use.

**E. Integrative Theories**

The following four theories have integrated cognitive- affective, learning, commitment and attachment, and intrapersonal pieces in the puzzle of substance use. Jessor's (Jessor et al., 1968; Jessor et al., 1991; Jessor & Jessor, 1977) problem-behaviour theory asserts that adolescents who are prone to one problem behaviour (e.g., delinquency) are also prone to other problem behaviour (e.g. , marijuana use). The theory deemphasizes cognitive-affective influences. The nature of direct and indirect effects is also not clearly described. Unlike Jessor's theory, Oetting and Beauvais's (1986a, 1986b, 1987) peer-cluster theory specifies direct effects for proximal variables (i.e., peer influences) and indirect effects for more distal variables (i.e., familial and intrapersonal variables). The merits of this theory lie in its comprehensiveness and specificity. The main constraint of the theory is the fact that involvement with substance-using peers is the only direct cause of substance use. Recently, Sher's (1991) model of vulnerability explains why children of alcoholics are vulnerable to alcohol abuse. Sher stresses the role of substance-specific expectation (of cognitive-affective theory), parental substance use (of social learning theory), school failure (of social ecology model), and emotional distress and inadequate coping skills (of multistage social learning model). The author stresses that these mediating factors have biological origins which make the model so different from previous theories. Finally, Huba and Bentler's (1982) domain model tries to articulate many (over 50) causes of substance use. These causes are grouped into four general domains such as biological (genetic influences), intrapersonal (personality, traits, and affective states), interpersonal (characteristics of persons who provide social support for the adolescent) and sociocultural (market availability of substances and social sanctions against substance use). The domain

model provides a complex but useful framework for looking at the causes of substance use.

To sum up, the review analyzed five classes of theories about the causes of substance use. There is considerable difference in the focus of each theory. The limitations of these theories are as under. First, the role of moderator variables has received little attention. Second, the models have said relatively little about the contributions of gender or ethnicity in substance use. Finally, models fail to explain whether different substances have similar etiologies or whether two substances have diverse causes. Consequently, the cause of substance use remains a puzzle with numerous pieces (i.e., constructs) and several strategies (i.e., theories) for assembling the pieces. Social scientists still have many of the pieces but do not know how they all fit together.

It is argued that a majority of Lettieri et al.'s (1980) 43 different theories on drug abuse are psychosocial theories. Theories propounded by researchers, on substance abuse, from several disciplines can be grouped into seven basic categories. These are (1) Pharmacological theory; (2) Biological theories which include genetic theory (family studies, genetic marker studies, and twin and adoptee studies), and physiological theories; (3) Psychological theories which include trait theory, psychodynamic or psychoanalytic theory, and behaviour theory; (4) Sociocultural theories which again include systems theory, deviant behaviour theory, subculture theory, environmental or social theory, cultural and anthropological model; (5) the Medical model; (6) the Disease model; and (7) the Public health model.

Despite different perspectives and many explanations that exist to account for substance abuse, there is no one theory that explains all aspects of drug abuse. Rather, most theories attempt to focus either sociological, psychological, or biological variables as the predominant factor.