

**THE SOCIAL AND PSYCHOLOGICAL  
FACTORS OF DROP-OUTS (13 - 18 YEARS) IN RELATION  
TO DRUG ABUSE IN MIZORAM**



*Thesis Submitted for the Degree of*  
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*by*

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**DECLARATION**

I, Vanlalhruaii, hereby declare that the thesis '**The social and psychological factors of drop-outs (13-18 years) in relation to drug abuse in Mizoram**' or any part thereto has not been submitted for any degree in North-Eastern Hill University or any other University.

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## CHAPTER-I

### INTRODUCTION

Drug abuse is one of the most serious challenges being faced by the contemporary societies. It is a multi-faceted phenomenon with combined effects of social, familial and psychological factors. It is a behaviour whose manifestation depends upon the complex drug-individual-society relationship and which is deeply rooted in the socio-economic-cultural fabric of the society. The desperation to belong is universal. When an individual finds himself isolated for psycho-social, economic or cultural reasons, his desire for belonging leads him to similar people who also feel isolated and may have sought escape or relief on drugs. The techno societies, being complex, do not offer the individual enough scope to maintain a sense of identity. The situation drives them to plug into one or more social sub-cults. As societies move up, the frustrations of the individual also multiply. One starts looking for a cult wherein these frustrations could at least be consolidated, if not relieved. In this way, a real drug culture develops. The drug culture tends to isolate the drug abuser from the general normative structure of the society, which they consider hostile and by whom they are often considered alien or deviant.

In the last two decades, the tentacles of drug abuse have spread so alarmingly that it is causing serious concern to the international community. Drug abuse is now no longer limited to traditional user-groups, the youths of the industrialised urban areas. The scourge is spreading to the youths of the rural areas and even school children. Unlike other types of disorder, the addiction illustrates a peculiar "contagion" or "infection" in that a special problem exists. This phenomenon in addiction is the introduction of others to the use of drugs and thereby expanding the social network of addiction. It was estimated by Bourne and Ekstrand (1976) that each addict introduces an average of six others to narcotics.

The drug abuse disorder has been worsened by the emergence of a new paradigm to already existing problem, i.e. formation of a visible link between intravenous drug use to human immuno-deficiency virus (HIV) and Aids. Now the formidable task posed before human kind is not only the prevention of drug use alone, but the prevention of HIV infections, use of needles and pricks in the skin by the drug users. The drug problem is therefore a major concern of humanity which has taken as its toll a whole generation, perhaps more, and as one can well expect many more will be its victims. All indications point to the fact that the battle against drug abuse is going to

## I.1 THE WORLD SCENE

Drug Trafficking has assumed global dimension. The increase in illicit drug trafficking has been accompanied by its growing abuse. The countries through which the trail of death passes become victims of the menace as much as those who are intended to be corrupted for financial gains. Today, the drug culture has pervaded the whole world. The alarming tentacles of illicit drug traffic and abuse have reached into virtually every nation.

Today, illicit drugs have become the world's most organised and high profit industry. There are regular markets and supply lines that extend to all parts of the globe. According to Beena Menon (1989), the four major supply complexes of illicit drug traffic recorded are:

- i. The French Connection: Turkey, France, Western Europe, South America, Canada and USA.
- ii. The Golden Triangle: Remote border areas of Myanmar, Thailand and Laos.
- iii. The Golden Crescent: Pakistan, Iran and Afghanistan.
- iv. Mexico and West Coast border areas.

The report of the International Narcotics Control Board for 1993 gave a world wide account of the magnitude of drug trafficking and abuse. Starting with the African countries, the abuse of heroin and cocaine and the abuse of certain psychotropic substances and cannabis, stimulants, hypno-sedative and minor tranquillisers, have been reported in all the regions of Africa. Several studies on cannabis use have been made in South Africa, Nigeria, Morocco and Egypt.

The situation in Central America and Caribbean is even more serious. The alarming increase in drug abuse has led to unprecedented growth in crime rate and in the number of drug-related deaths. In several South American countries, illicit drug production, manufacture, traffic, and abuse are consequences and at the same time, causes of fundamental economic and social problems. Besides cocaine and cannabis, the abuse of amphetamines, anxiolytics and other pharmaceuticals are reported in this region. In the combined areas of Bolivia, Peru, Colombia and Argentina, there were about five million users of cocaine as far back as 1970. Cannabis use is widespread in Brazil, the West Indian Islands and Mexico. Canada registers an increase in the abuse of volatile solvents, particu-

larly gasoline, among young people in rural areas.

In the United States, according to the National household survey on drug abuse (1992), the number of abusers of any illicit drug fell to 11.4 million from 12.6 million in 1991. However, there was an increase of 7 percent in the number of drug related emergencies cases, indicating increased purity of drugs, increased potency and more dangerous methods of administration. Millions in the United States regularly use sedatives, stimulants and tranquillizers. Marijuana use is very extensive particularly among the intellectuals, artisans, non-conformists and high school and college students who are alienated, dissatisfied and rebellious. Glue sniffing, gasoline or solvent inhalation, and miscellaneous other substances have also become popular with teenagers.

In Asia, the major psycho-active drugs used are alcohol, cannabis, opium and heroin. There is also considerable use of other indigenous substances as well as manufactured sedative and stimulant-drugs. The countries where drug abuse is considered a major problem include Hong Kong, Thailand, Japan, Singapore, South Korea, India and Sri Lanka

In Pakistan, as reported by Sain (1992), the smoking of charas was the most common type of abuse followed by opium-eating and smoking which remained widespread. The number of heroin-users were increasing at the rate of 40,000 annually.

Other Asian countries with recognised significant non-medical use of narcotics include Singapore, Malaysia, Korea, Laos, North and South Vietnam, and the Philippines. Indonesia and particularly Sumatra and Nepal have extensive use of Cannabis. The areas constituting the Golden Triangle and the Golden Crescent are particularly well-known for illicit drug-trafficking.

In the Middle East, the use of cannabis is widespread in Turkey. Khat leaves containing amphetamine-type stimulants are extensively used in Saudi Arabia, Kuwait and Yemen. In Iran, opium is the main drug of abuse and the number of abusers, according to the official sources, till 1990, was estimated to be one half million while heroin users were estimated at 1,00,000, comprising youth in urban areas. The unofficial statistics as reported by Sain (1992) will be much higher.

In Europe, cannabis remains the main drug of abuse. The use of heroin also continues to be a major problem. An increase in deaths related to the abuse of drugs has been reported in several countries of the region.

Considerable use and abuse of a wide variety of manufactured drugs, sedatives, stimulants and tranquillisers are known to occur in most of the large cities in Western Europe, particularly barbiturates, amphetamines and phenmetrazine (preludin) particularly among young people.

In Great Britain, the misuse of amphetamines and cannabis is rapidly increasing. Opiate addiction is markedly seen among young people. A B.B.C (1984) survey found that 39 percent of a sample of British people between the ages of 17 and 34 claimed to have used cannabis.

Drug abuse in all forms, according to Mc Tarish (1996), continued to be one of the biggest killers in Australian society, with more than 25,000 people dying each year from drug abuse related causes. In New Zealand too, the abuse of heroin is considered a serious problem. Other drugs commonly abused are cannabis, cocaine and amphetamines. In the Oceanic region, the problem of drug abuse seems to be limited to the abuse of cannabis.

In Russia, according to the 1989 official reports, the number of addicts were 1.54 million. But the number of addicts away from the dragnet of statistical observation was definitely much higher as Russian sociologists opined that the actual number was 10-12 times higher, indicating that there were 15 to 20 million addicts in Russia.

As Fort (1970) Puts it, "The drug(ged) world serves as a barometer of human society—an indicator of underlying social illness and a warning of existing and approaching social storms. The storm is mounting".

## 1.2 THE INDIAN SCENE

Sandwiched between the Golden Triangle and the Golden Crescent, India has become a major transit country for the smuggling of drugs. In addition, there is Nepal in the north which is a major source of supply of marijuana and hashish in the world market. With the Golden Crescent countries in turmoil, India and Pakistan mafias are said to be liaisoning with global syndicates at different points on the drug route, with Mumbai as the main junction. With the crack down on drug trafficking in Iran, strict control of poppy cultivation in Turkey and the explosive situation in Afghanistan, Mumbai has become the wholesale market for most of Asia. Heroin, hashish, marijuana, opium, cocaine, morphine and methaqualone flow in through the entry point located in the country's international border with Pakistan, Burma and Nepal. The spill-over from drug trafficking has made India a virtual dumping ground and the rise in addiction seems to tally with the flow of drugs in the country.

Jammu and Kashmir, Delhi, Uttar Pradesh, Rajasthan, Gujarat, Tamil Nadu and many others have become havens for drug smugglers. What is most tragic is that India's transit points are fast becoming the consuming ends. Sinha (1980) reported that "heroin and hashish are in great demand in the metropolitan cities. Delhi alone has more than 1,00,000 people who are either traffickers, peddlers, street pushers or addicts".

Twenty-five years back, drug addiction was only a problem but not a menace in India. Today, the abuse has assumed frightening dimensions predominantly among the youth. The Ministry of Social Welfare, Government of India has recorded 8,11,592 drug addicts till December 1992. The Statistics was confined to those who had registered themselves with some clinics or de-addiction centres. The unreported cases would be many times the recorded figure.

According to UN. Narcotics Control Strategy Report of February 1993, There were about one million heroin addicts and four million opium addicts in India. Nearly 13,000 people were booked for drug trafficking in 1992. While 16,000 people were registered with the central de-addiction centres in 1986-87, their number had shot up to 97,000 in 1991-92, over six times increase. The position was indeed alarming.

### 1.3 NORTH EAST INDIA: THE DRUG SCENE

The entire North-East region has come under the grip of the problem of drug abuse and trafficking. The strategic geographical location of these states, most of which have long borders with Myanmar and other countries have created a perfect setup for a major 'Drug - invasion'.

Illicit drug trafficking entering from Myanmar touches Moreh in Manipur on the Indian border and moves up to Imphal for distribution. Recent disturbances caused by Kuki-Naga clashes led to the diversion of drug traffic from Moreh in Manipur to Champhai in Mizoram. The movement of drug is facilitated by the terrain which is inhospitable for monitoring agencies. The local tribal people can however move freely across the international border without any passport or visa restriction. Originally, the agreement had been reached to ensure easy supply of essential goods to the tribals, but now it is misused both by genuine tribals and other couriers posing as tribals exempted from passport and visa restrictions.

Within the Indian border, the heroin finds its way to major consumption centres like Imphal, Kohima, Aizawl, Dibrugarh, Guwahati, Shillong, Agartala and Siliguri. The network, thus extends to almost all the states of

the North-East, Manipur, Mizoram, Assam, Meghalaya, Tripura and going down to the streets of Calcutta. The drug smuggled in the North-Eastern region is also being consumed locally in large quantities. Till 1994, the number of addicts in Manipur alone was reported to be around 40,000.

Karna (1989) reported that in Manipur, phensedyl a cough linctus was the most abused drug but among the hard drugs, heroin, popularly known as Number four was the most frequently used drug. Besides these, tranquilisers like calmpose, placidox, valium, and other cough linctus like benedryl, corex, tossex, ephedrex, and painkillers like proxyvon and pethedine were the most common drugs of abuse.

Increasing drug use in Guwahati, according to Karna (1989), was manifested in the open use of ganja in public places; drug being sold without prescriptions; increasing number of drop-outs in colleges; increasing statistics of addicts visiting hospital; increasing sale of cough syrups, etc. Cannabis was the most popularly used drug in Guwahati followed by heroin, phensedyl and brown sugar.

In Mizoram, most of the Narcotic drugs seized by the Mizoram Police and the Mizoram Excise department come from Myanmar across the border. Only recently, drugs began to be brought in from elsewhere like Delhi, Calcutta and Bombay. The available figures for 1994 revealed that among the 933 drug addicts in Aizawl alone, there were at least 81 girls. In 1998, the statistics had risen to 3500.

The new trend in drug abuse that has developed in the past 5 or 6 years is that of getting hooked to proxyvon, which is medically used as a pain-killer. The alternative to it include nitrosun, diazepam, soxygon, codeine, corex, phensedyl, etc. The other substances of abuse include deliriant, like solvents, glue, inhaling of petroleum fumes, gasoline, lighter fluids, paint thinner, varnish, etc., which are cheap and easily available. Ganja is also a common drug of abuse.

#### 1.4 DRUG : A CONCEPTUAL ANALYSIS

The word 'Drug' was derived from the Dutch word "Droog" meaning "to dry". It probably came into use because most early drugs were made from dried plant tissues. Drug has been interpreted in different ways.

According to W.H.O. (1981), "A drug is any substance that when taken into the living organism may modify one or more of its functions".

Mc Connel (1977) explained that "A drug is any chemical which, when taken in relatively small amounts, significantly increases or decreases cellular activities somewhere in the body".

O' Toole (1989) described a drug as any substance (usually a chemical) which influences our bodies or emotions.

Wilson and Wilson (1961) said, "Drugs are substances used to influence the activities of the cells and organs of the human body".

According to Ghonglah (1987), "A drug is a chemical which people use for medical purposes; a chemical which has the power to change a person's mood or the way he thinks about things; a chemical which people take for pleasure; a chemical on which a person who takes it may become dependent".

As explained by Mc Mohan (1977), "Drugs refer to those mind-altering substances whose sale without prescription is illegal".

A drug is defined by Singh and Singh (1993) as any substance introduced into the body to change the way the body systems work.

Scientific group of W.H.O. stated that the term drug is used or intended to be used to modify or to explore the physiological systems or pathological states for the benefit of the recipient.

A drug, said Sekharan (1989), is a substance that has an effect upon the body and mind.

Nadkarni (1992) described a drug as a substance not normally present in the body and which is ingested to meet a psychological, social or medical need.

## 1.5 CLASSIFICATION OF DRUGS

Drugs may be classified on the basis of the effects they have on the user. These may be as follows:-

### 1.5A SEDATIVES

This class of synthetic chemicals collectively known as barbiturates include pentobarbital, secobarbital, barbital, selobarbital and anobarbital. They produce a general depression of activity in the brain. They reduce anxiety, slow body functions, produce relaxation, a feeling of wellbeing, and a decrease in attentiveness. Exces-

sive dose may result in impairment of judgement, loss of emotional control, slurred speech, tremor and occasionally lead to coma and death.

Barbiturates combined with alcohol are particularly dangerous as the effects of two drugs get multiplied by a drug interaction. Barbiturates increase para-sympathetic activity and act as depressants. They slow down the beating of the heart, take blood away from the surface of the body, retard the rate of breathing and generally make it more difficult to react quickly to any emergency.

### 1.5B STIMULANTS

Stimulants such as benzedrine, dexedrine, methedrine, cocaine (cocoa), methaqualone, pep pills, etc. are included here. Considered as "Uppers" or "psychological energisers", they make one physically and mentally more active. They produce increased alertness, wakefulness, euphoria, and even exhilaration. Students who cram for examination tend to abuse these drugs.

Heavy and chronic users of amphetamines tend to become irritable, impulsive and unstable in their period adjustment. They may also commit acts of violence. The drug related conditions of suspiciousness and rapidly changing mood make the user sensitive to otherwise minor frustrations and thus increase the potential for aggressive and impulsive acts. The prolonged consumption of amphetamines leads to a high percentage of "schizophrenic like" psychotic episodes which can almost be indistinguishable from paranoid schizophrenia except that their action disappears some 3 to 6 days after discontinuation of the drug.

### 1.5C NARCOTICS

The drugs like opium, morphine, cocaine, heroin, methadone and pethedine are classified as Narcotics. The drugs derived from the poppy plant are known as 'Opiates'. They have been used most effectively as analgesics (pain-killers) throughout the centuries.

Morphine induce drowsiness and lethargy and reduces anxiety or discomfort. Heroin is a synthetic drug derived from morphine. Out of all the illegal drugs, heroin and morphine are the most physically addictive. Their users quickly become tolerant and steadily increase the dosage "to the normal" daily dose level. Most abusers develop psychological dependence too. Heroin acts as depressant, relieves anxiety and tension, reduces sex, hunger and other primary drives.

Heroin is available through illegal channels, it is never prescribed. It is injected by hypodermic needles directly into the vein.

### 1.5D PSYCHEDELICS AND HALLUCINOGENS

Cannabis, ganja, charas, bhang, mescaline, psilocybin and L.S.D. (Lysergic Acid Diethylamide) are the drugs included here. The term psychedelic is generally applied to any drug whose primary effect is to induce an altered state of consciousness. The hallucinogens are a class of drugs that produced marked changes in mood, sensory perceptions, thinking and emotions. They form a class because of their effects.

L.S.D induced states of consciousness, remarks Prashant (1993) are vivid perceptual distortions or hallucinations, including spatial relationships, apparent flexibilities of solid masses, intensification of colour, sharpening of contours and synesthesia.

Psilocybin produces psychotic like symptoms including hallucinations, paranoid ideas, hypochondriachal and hysterical complaints and thought disturbances.

Marijuana users may feel an euphoric sense of well-being, drowsy and contented and enhanced perception, a change in time perception, a lowering of social inhibitions, change in thought processes, etc. The drug is not physically addictive but its user can become psychologically dependent.

### 1.5E TRANQUILLISERS

Chloridiazepoxide, meprobamate, diazepam, scopolamine, campoz, benzodiazepines are a class of drugs very often medically prescribed and can give rise to psychological dependence. The psychological effects include reduction of anxiety, slowing down of body functions, relaxation, drowsiness and deep sleep.

### 1.5F ALCOHOL AND TOBACCO

They are the most widely abused drugs of the modern time. However, they are seldom considered drugs by the public even though their power to alter body functions and behaviour is well-known.

Ziegler (1984) observed, "Alcohol leads to increased anxiety and depression and to social withdrawal in heavy users. High alcohol consumption disrupts motor co-ordinations, balanced speech and intellectual judgement. Alcohol is linked to two-thirds of all domestic violence and one-third of child abuse cases.

O'Toole(1987) said, "tobacco is thought to reduce tension and relax the body but leads to habit formation and to addiction. Together, alcohol and tobacco provide an escape mechanism.

### 1.5G DELIRIANT (INHALANTS)

Sniffing glue, gasoline, lighter fluid, paint thinner, varnish, shellac, kerosene oil, nail polish remover, aerosol-package products, etc. produce symptoms similar to intoxication followed by excitement and exhilaration. Then there is loss of co-ordination, disturbed perception and extreme confusion. These chemicals which give off fumes or vapours when inhaled may lead to psychological dependence.

### 1.5H PRESCRIPTION DRUGS (OVER THE COUNTER DRUGS)

They include mandrax, proxyvon, phensedyl, corex, coscopin, etc. These are the drugs which are used for medical purposes to get relief from mild depression, narcolepsy, cough and cold, etc. They are extensively abused by youngsters who are in for "cheap kicks", as other drugs of abuse are expensive and cannot be afforded. Mandrax are no longer made legally because of its extensive abuse. Cough suppressants like corex and coscopin contain codeine. Their abuse is extensive because of easy availability. Proxyvon, available in small capsules in most drug stores is the most extensively abused drug in Mizoram. Diluted with water, it is taken intravenously.

### 1.6 DRUG ABUSE : A CONCEPTUAL ANALYSIS

Drug abuse is commonly used to refer to the misuse of all kinds of legal and illegal drugs. It has been defined in different ways.

Drugs abuse, says Chowdhury (1989), is the excessive consumption of drugs regardless of whether an individual is truly dependent on it. It also denotes the repeated use over a certain span of time of any drug that affects the central nervous system in a manner that the individual's normal behaviour and his occupational functioning is affected.

Blum and associates (1970) maintained that drug abuse refers to the regular or excessive use of a drug to the extent that it is damaging to a person's social or vocational adjustments, or to his health, or is otherwise specifically detrimental to society.

Drug abuse means “the self administration of chemicals for purposes other than those prescribed by medical and social practice”, according to Singh and Singh (1993).

Drug abuse has also been defined as “the consumption of a drug apart from need or in unnecessary quantities”, by Wilson (1968).

“Use of drugs, usually by self administration, for other than legitimate purposes”. Bhat (1978) says that such a use is inconsistent with or unrelated to the accepted medical practice.

Nadkarni (1992) pointed out that drug abuse is the use of a drug which is regarded by the society as harmful to the individual or to the society.

Singh and Singh (1993) feel that the term drug abuse is ordinarily used “to refer to non- therapeutic voluntary use of drugs such as a method of defensive coping against anxiety, stress or pain or use of drugs for pleasure or experience.

When the individual takes a drug for other than medical reasons in amount, strength, frequency and manner that damages the physical and mental functions, it is said to be abused.

Lobo (1986) refers to drug abuse as an excessive consumption of a drug regardless of whether an individual is addicted to it or not. He said that an abuser may or may not be an addict, an addict is necessarily a drug abuser.

## 1.7 DRUG ADDICTION, DRUG DEPENDENCE, DRUG HABITUATION : A COMPARATIVE ANALYSIS

It is sometimes difficult to sharply differentiate the varieties of problematic drug consumption that have been clinically referred to as drug addiction, drug dependence and drug habituation.

Drug addiction and drug dependence are two terms which have been used interchangeably. Drug addiction was a more common usage in the past but has in recent years mostly been replaced by the term drug dependence. However, if one wishes to do so, a line of distinction can be drawn between them. Drug dependence is nearer the term drug addiction than drug habituation. Addiction refers to the state of utter and complete slavery to a habit. It is the outcome of drug dependence, the manifestation of a person's invariable craving for a drug on which he has developed psychological and physiological dependence.

There are some people who firmly assert that drug dependence is not to be understood as addiction to a drug or drug addiction. They maintained that drug dependence is a psychological phenomenon while drug addiction is physiological. Traditionally, drug dependence was understood in the sense of some sort of psychological dependence on drug as effected by regular intake of drug without which the patient feels that he will not survive. When a person becomes dependent on a drug, it becomes extremely difficult or impossible for him or her to put a stop to the habit. In modern times, however, drug dependence is taken to mean both physiological and psychological dependence on drugs.

A look at the meanings given by various researchers and social scientists show common implications.

Buss (1979) 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 behaviours but also serious threats to health and addiction leads to cumulative problems because addicts usually require more and more of the drug leading to physiological accommodation to the drug".

Drug addiction as described by W.H.O (1950) is "a stage of periodic and chronic intoxication derimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic)". Its characteristics include :

- i) an overwhelming desire, a need (compulsion) to continue taking drugs and to obtain it by any means;
- ii) a tendency to increase the dose;
- iii) a psychic (psychological) sometimes physical dependence on the effects of the drugs.

White and White (1975) define drug dependence as the process of chemicals that affect the central nervous system in a way experienced as pleasurable but hazardous to health if taken in immoderate amounts. More importantly, from the clinical point of view, their intoxicating effects may acquire a compulsive allure that it is so powerful as to defy rational control.

Drug dependence is a psychological and physiological phenomenon where it becomes extremely difficult or impossible for the drug user to put a stop to the habit. Psychological dependence occurs when a drug is so central to the person's thoughts, emotions and activities that it is extremely difficult to stop using it, or even stop thinking about it. It is marked by intense craving for the drug and its effects.

Physical dependence occurs when a drug user's body becomes so accustomed to a particular drug that he can function normally only if the drug is present in his/her body system. Without the drug, the user may experience a variety of symptoms ranging from mild discomfort to convulsion. It has also been described as the development of an altered physiologic state which require continued administration of a drug to prevent the appearance of a characteristic illness, termed as "abstinence syndrome".

Parikh and Krishna (1992) consider emotional dependence as "the use of drug as a substitute to some adaptive behaviour".

W.H.O(1973) distinguished between drugs leading to true addiction and those that merely result in habituation. The addictive drug always produce compulsive craving sooner in individuals whose psychological make-up leads them to seek escape in drugs. In contrast, the habit forming but non-addictive drugs never produce compulsive craving, although the individual may find their effects desirable and may quickly acquire the habit of taking them. Withdrawal need not cause significant difference or disturbance.

Drug habituation includes a desire or a compulsion to continue taking the drugs in order to secure the sense of well being which the drug engenders, with little or no reason to increase the dose. There develops some psychological dependence upon the drug but no physiological dependence which leads to withdrawal symptoms. Detrimental effects are primarily restricted to the individual himself.

## 1.8 TERMINOLOGY

In the following paragraphs, the terms frequently associated with drug abuse have been explained.

PSYCHOSES It is marked by severe personality decompensation, marked impairment of contact with reality, with symptoms like delusions, hallucinations, emotional blunting and behaviour that may be called bizarre. There is frequent loss of orientation to environment in respect of person, place or time.

Emotional symptoms like extreme exaggeration of mood is defined as affective psychoses. Organic psychoses are marked by memory and intellectual deficits. When cognitive disturbances predominate, the diagnosis is schizophrenia.

NEUROSIS It is characterised by mal-adaptive avoidance behaviour with mild or moderate impairment of personal and social functioning. The neurotic person usually feels miserable, has physical and emotional symptoms such as continual worrying and heart palpitations and has great difficulty in getting along with others.

PSYCHOPATHIC/SOCIOPATHIC Personality disorders characterized by lack of moral development and a tendency to act in an aggressively anti-social manner. Sociopathic disorder is marked by disregard for social conventions and responsibilities and lack of inter-personal loyalty, apathy and anti-social tendencies.

PSYCHOSOMATIC Personality diseases that frequently have a high psychological component are called psychosomatic. There is persistent physiological tension caused by psychogenic factors.

NARCOTICS The term is generally used as a legal classification for the stronger and more dangerous drugs, e.g. opiates, opium, morphine, heroin cocaine, etc.

MULTIPLE DRUG USE It refers to taking of two or more drugs simultaneously to produce a greater effect.

ABSTINENCE SYNDROME The need to take the drug regularly to avoid withdrawal distress. Symptoms of distress appear when there is an abrupt or complete withdrawal of the drug. They are purposive and non-purposive.

i. Purposive : Highly individualised patterns of behaviour like threatening suicide or violence, assuming bizarre posture and exaggerated distress.

ii. Non-Purposive : Symptoms consist of yawning, tremors, muscle twitches, restlessness, nausea, vomiting, diarrhoea, anorexia, weight loss, cardiac and respiratory rates and blood pressure, elevation of blood sugar, etc.

OVERDOSE It is the dose that can cause sudden and serious physical or mental damage. An overdose may or may not be fatal depending on the drug and the amount taken. The dose which is excessive for the patient and which causes what is clinically assessed as a toxicological situation is an overdose.

TOLERANCE When repeated administration of a drug results in a progressive decrease in some of the effects, this decline is called tolerance. Increasing doses are required to produce the same effects. This leads to more exposure to the drug and almost certainly to greater frequency of administration.

RELAPSE After a long period of sobriety or abstinence, a drug user may revert back to the use of drugs.

PREVALENCE The ratio of the number of the individuals using one or more substances of a specific category of drugs and the total number of persons covered in the study.

FREQUENCY OF USE The number of times an individual uses one or more substances of a specific category of a drug, e.g. experimental, regular, situational, chronic, etc.

ANXIOLYTIC Drug reducing anxiety and tension.



### I.9 STATEMENT OF THE PROBLEM

Today the drug culture is very wide and extensive and has become a serious problem eating into the very fabric of our society. It is wrecking the Indian society and the future citizens of the country, the youth from within. It is a grim reality which one cannot afford to ignore or overlook. The main social menace of drug abuse is that it results in mental degeneration which is a cause of great concern. Potential talents which could have been actualised in course of time are destroyed because of drug involvement. Drug destroy human motivation and willpower, making the victim afraid of shouldering normal human responsibilities.

The presence of the problem in school and among youth is a symptom of social conditions and personality problem. It is a part of a larger one—of the adult drug culture. What should be subtle, subdued and kept within reasonable decent standards—especially in the presence of children, are blatantly talked about and unabashedly practised in public. This naturally arouses curiosity and incalculable damage to the psyche of the children and the immature.

In modern times, the use of drugs has wreaked havoc, affecting generation after generation of young boys and girls. Newer and more dangerous drugs are appearing on the scene and what is alarming is that they are filtering down to highly vulnerable sections of society including school and college students. The majority of drug victims are youths, the lifeblood of our Nation, studying in schools, colleges and universities. Once used to drugs, they begin to skip school, college or university. Educational careers are thus disrupted, resulting in increased number of drop-outs. The wastage in terms of money, time, talent and human resources is tremendous.

The extent and nature of the problem of drug abuse among the young people of Mizoram today is serious and there are disturbing signs which show that the situation is likely to worsen and get out of hand, if adequate

measures are not adopted to curb the evil. The problem to be investigated can thus be specifically put as "A study of the socio-psychological factors of drop-outs (13- 18 years) in relation to drug abuse in Mizoram".

#### 1.10 JUSTIFICATION OF THE PRESENT STUDY

The nature and extent of drug and substance abuse vary from country to country, and from community to community. The substances, the people and the circumstances vary from place to place, from culture to culture. In many instances, the perceived characteristics of particular group of people using drugs vary and their supposed reasons for using them vary widely. It is therefore imperative for each community to take steps to identify its own drug abuse problem. The present study is a step in this direction.

The causes of drug abuse have been recognised in several international forums. The Comprehensive Multi-disciplinary Outline (CMO) of the International Conference on Drug Abuse and Illicit Trafficking (ICDIAT) observed that to give attention to the fundamental causes of the problem of drug abuse, social, economic and cultural factors must be taken into account. The conference went on to suggest that research be undertaken to identify causes so that they could be eliminated. It suggested as potential contributory causes "..... social and family circumstances, housing, employment and level of education".

Whatever the cause may be for abusing drugs, a problem is perceived and a solution is sought. Effective problem-solving requires careful definition of the problem in descriptive rather than emotional terms, evaluation and selection of methods, tools and strategies relevant to the problem. One must acquire a vantage point from which to view drug use and the phenomena associated with it and the lens through which to view drug, man, society and the interactions among them, the number and kinds of discrimination made within each factor, the nature of the response and the relative ability of various institutions and professions to intervene most effectively.

A study of social and psychological correlates of drug abuse among drop-outs in Mizoram will put major emphasis on the individual as the active agent in the drug-individual context formulation. It will help in highlighting the social and psychological factors present in the socio-economic and environmental conditions which lead to psychological stress. The socio-economic status, housing, family, education, peer-factor, urbanization, etc., are seen as the breeding ground of the more personal factors as poor living conditions, broken homes, parental

deprivation, low achievement, negative peer influence, prejudice, discrimination, etc., all of which add to the stress and strain of living giving rise to anxiety, tension, frustration, depression and other psychological maladies.

The psychological make-up of drug abusers who have dropped out from the normal stream of academic life are studied in terms of specific personality traits because psychological disorders are explained in general, through personality characteristics. Addictive behaviour is one which is manifested in personality structure as drug dependence is in itself a serious psychological disorder. Despite the tendency to see undesirable behaviour always as the result of undesirable aspects of the social system, one must acknowledge that much of what is disapproved is essentially linked with things that are approved of and valued.

The main purpose of the study is to identify the social and psychological factors responsible for drug abuse with reference to drop-outs in Mizoram. Although several studies have been conducted both outside and within the country on drug abuse, very limited studies are available in Mizoram especially on the social and psychological correlates of drug abuse and which specifically covers the drop-outs are not available.

Moreover, most of the studies conducted on drug abuse were done ten or twenty years back. In a rapidly changing world where the youth is exposed to a variety of social, psychological and economic conflicts, the use of such studies become limited and lose their relevance to present-day situation.

The present study would enable one to examine the varied aspects of drug abuse both from the point of view of psychological aspect and that of social aspect which will be useful in making our proper diagnosis of the drug-abusing drop-outs. The study is aimed at focusing the correct diagnosis through social and psychological factors which will be of great help in working out a short-term and long term programme for its prevention and cure. A study taking up a single factor or approach would not be able to provide a dependable understanding of the phenomenon of drug abuse and its relation to dropping out.

The effort of understanding the phenomenon of drug abuse and its disruptive influence on educational careers through the study of social and psychological factors will, one hopes, shed light on the dark areas of human errors and weaknesses, particularly in the educational sphere. Such a study is urgently required in Mizoram to prevent further escalation of the problem. The youth must be brought back to the main stream of cohesive educational growth and development.

### 1.11 OBJECTIVES OF THE STUDY

The study of socio-psychological factors of the drop-outs (13-18 years) in relation to drug abuse in Mizoram has been initiated keeping in view eight primary objectives. These are as follows:-

- a. To identify the psychological factors related to drug abuse in drop-outs (13 to 18 years) of Mizoram.
- b. To identify the various social factors contributing to drug abuse in drop-outs (13 to 18 years) of Mizoram.
- c. To find out the type, nature and pattern of drug abuse in drop-outs (13-18 years) of Mizoram.
- d. To find out the differences between different groups of drug abusing drop-outs on psychological factors.
- e. To find out the differences between male and female drug abusing drop-outs on the above factors.
- f. To identify differences between the psychological and social variables for different educational levels of drug abusing drop-outs.
- g. To study the parental perceptions, awareness and attitudes towards their drug abusing children.
- h. To study the various measures taken up in Mizoram to check drug abuse and extent to which these measures have succeeded.

### 1.12 RESEARCH HYPOTHESES

The formulation of hypotheses is an important part of any research work. Without hypotheses, the research would go astray. The following null hypotheses have been formulated to test certain selected variables taken up for study:

- a. Various psychological factors are not responsible for drug abusing drop-outs.
- b. The social factors do not influence the behaviour of drug abusing drop-outs.
- c. There is no variation in the type, nature and pattern of drug abuse in drop-outs.
- d. There is no statistically significant difference between the hard core and casual drug abusing drop-outs on psychological factors.
- e. *There is no statistically significant difference between the male and female drug abusing drop-outs on the above factors.*

- f. There is no statistically significant difference between the psychological and social variables for different educational levels of drug abusing drop-outs.
- g. Parental perceptions, awareness and attitudes are not important factors in the drug abusive behaviour of dropped out children
- h. Effective measures have not been taken up in Mizoram to check drug abuse.

### 1.13 OPERATIONAL DEFINITIONS

The terms used in the title of this study are described as follows:

For studying the social factors contributing to drug abuse in drop-outs, a number of variables have been taken up. These include :-

- i. the living conditions,
- ii. the family income,
- iii. parental education,
- iv. educational status and performance,
- v. peer involvement and friendship patterns,
- vi. home environment and parental care,
- vii. participation in social activities,
- viii. religious affiliation and church involvement, and
- ix. physical health

There are various personality characteristics of the drop-outs which may have bearing on their drug use. For this purpose, the HSPQ which measures fourteen dimensions of personality has been used. These dimensions of personality are as follows :-

- reserved vs warm-hearted,
- less intelligent vs more intelligent,
- affected by feelings vs emotionally stable,

- undemonstrative vs excitable,
- obedient vs assertive,
- sober vs enthusiastic,
- disregards rules vs conscientious,
- shy vs adventurous,
- tough-minded vs tender-minded,
- zestful vs circumspect individualism,
- self assured vs apprehensive,
- group-dependent vs self sufficient,
- uncontrolled vs controlled,
- relaxed vs tense.

The drop-outs here mean adolescents between the ages of 13 - 18 years whose educational careers had been disrupted due to drug use and were therefore no longer in the mainstream of academic life. The concept of drug abuse used in the present study means the misuse of all kinds of drugs, legal and illegal and its consumption apart from medical need.

#### 1.14 SIGNIFICANCE OF THE STUDY

Through an analytical study of the social and psychological factors of the drop-outs (13-18 years) in relation to drug abuse in Mizoram, the study attempts to establish the influence of social and psychological factors of the drop-outs in the development of drug abuse problem.

Attempts have been made to derive reliable and valid knowledge about the addict's personality and his social environment so that this will help one in dealing with the problem more effectively and increase the understanding of one of the crucial behaviour problems of the Mizo society. This will, it is also hoped, help one in evolving effective strategies and preventive programmes for controlling the abuse of drugs in Mizoram.

There is ample evidence that familial factors such as parental attitudes, parental positivity, etc. play a significant role in drug abuse behaviour. It is felt that parental reaction to and acceptance of the drug problem, and how they deal with it subsequently are highly significant factors in dealing and tackling the drug problem. Taking these into perspective, the study covers the parents of the drug abusing drop-outs with a view to identifying their problems. Through these, the study aims to discover important aspects of the parent-child relationship and the disequilibrium likely to exist within this syndrome.

In the past two decades, since the outbreak of the drug epidemic in Mizoram when the tentacles of drug began to close in on hundreds of young people whose lives and educational careers had just begun, people began to wake up to the horrifying realities. Awareness about the dangers of drug abuse and its harmful effects began to be felt. It was at this juncture that counselling centres and de-addiction and rehabilitation centres hastily sprang up all over Mizoram, the initiative being taken by zealous individuals, social and voluntary organisations, religious bodies and churches as well as the Government. In their individual capacity, these centres have made all-out efforts to extend help to thousands of young people caught in the vicious net of drugs.

However, no systematic appraisal or assessment of the drug abuse preventive programmes and measures have been made so far. Therefore, an investigation into the functioning of these centres in Mizoram, the quality of treatment provided, the after-care and rehabilitation facilities available, the efficiency and efficacy of functioning, the extent of their success and failure, etc. would be of great significance in evolving preventive and intervention strategies.

### 1.15 SCOPE AND LIMITATIONS

The sample for the study is mainly drawn from the various counselling centres and de-addiction and rehabilitation centres spread over the three districts of Aizawl, Lunglei and Chhimitupui because drug abusers invariably seek treatment in these centres. However, there are a number of them who loiter around aimlessly or remain confined to their homes. These have been approached personally.

Drug abuse is considered evil in any society. Apart from drugs used for medical purposes, drugs are labelled as dangerous and their use illegal. Abuse of drugs does not receive any sanction - socially, medically, or legally. Thus, the trafficking, use and abuse of drugs are carried out with utmost secrecy, shielded from the eyes of

society and law. In this context, most drug abusers are generally unwilling to come out and expose themselves to social appraisal. No abuser is readily willing to divulge his thoughts, feelings, experiences, drug habits and patterns. The limitation on this account was a significant factor. A great deal of time, energy and tact had to be expended for acquiring reliable and relevant information from the subjects sampled. Collection of data therefore took up a sizeable chunk of time and caused considerable delay in the completion of the study

Approaching and gaining access to the parents of the drug abusers was again a stupendous task which again had the same limitation because most parents were not willing to admit openly the drug habits of their child. Wining the confidence of both the drug abusers and the parents of drug abusers was difficult even with the assurance of absolute confidentiality.

Lastly, the study covers the age group 13 - 18 years. Since there are a large number of drop-outs below and above this set age group, the number of drop-outs who fall within this range become limited. Moreover, since all drop-outs do not necessarily pick up the drug habit, the sample for the study became further reduced.