

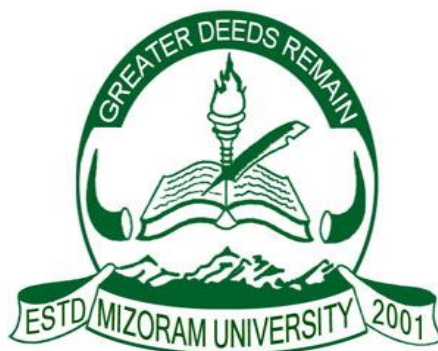
**FAMILY FUNCTIONING, FAMILY RESILIENCE AND  
QUALITY OF LIFE AMONG SUBSTANCE ABUSERS IN  
DE-ADDICTION CENTRES IN AIZAWL, MIZORAM**

**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE  
REQUIREMENTS FOR THE DEGREE OF DOCTOR OF  
PHILOSOPHY**

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QUALITY OF LIFE AMONG SUBSTANCE ABUSERS IN  
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**In partial fulfillment of the requirements of the degree of Doctor of  
Philosophy in Social Work of Mizoram University, Aizawl.**

**MIZORAM UNIVERSITY**

**APRIL, 2023**

**CERTIFICATE**

This is to certify that the thesis “*Family Functioning, Family Resilience and Quality of Life Among Substance Abusers in De-Addiction Centres in Aizawl Mizoram*” submitted by Esther Lalrinhlui Ralte for the award of Doctor of Philosophy in Social Work is carried out under my guidance and incorporates the student’s bonafide research and this has not been submitted for award of any degree in this or any other University or Institute of learning.

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**DECLARATION**

I, Esther Lalrinhlui Ralte, hereby declare that the subject matter of this thesis is the record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to do the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/Institute.

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I dedicate this thesis to my daughters Vanlalmangaihi and Vanlalhruitluangi.

**(ESTHER LALRINHLUI RALTE)**

Research Scholar

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### LIST OF ABBREVIATIONS

<b>Sl.No</b>	<b>Abbreviation</b>	<b>Full Form</b>
1.	AA	Alcoholic Anonymous
2.	AAY	Antyodaya Anna Yojna
3.	APL	Above Poverty Line
4.	AIHW	Australian Institute of Health and Welfare
5.	BPL	Below Poverty Line
6.	CBT	Cognitive Behavioral Therapy
7.	CNS	Central Nervous System
8.	FBO	Faith Based Organization
9.	FCC	Family Counselling Centre
10.	FES	Family Environment Scale
11.	FGD	Focus Group Discussion
12.	FRAS	Family Resilience Assessment Scale
13.	KTP	Kristian Thalai Pawl
14.	MHP	Mental Health Problem
15.	MI	Motivational Interviewing
16.	MSACS	Mizoram State AIDS Control Society
17.	MSD & RB	Mizoram Social Defense and Rehabilitation Board
18.	MSJ & E	Ministry of Social Justice and Empowerment
19.	MSU	Mizo Students' Union
20.	MZP	MIzo Zirlai Pawl
21.	NA	Narcotic Anonymous
22.	NACO	National AIDS Control Organization
23.	NHMRC	National Health and Mental Research

24.	QOL	Quality of Life
25.	PWI	Personal Well Being Index
26.	SAMHSA	Substance Abuse and Mental Health Services
27.	SES	Socio Economic Status
28.	SUD	Substance Use Disorder
29.	UNODC	United Nations
30.	WHOQOL	World Health Organization Quality of Life
31.	YMA	Young Mizo Association

## **CHAPTER -I**

### **INTRODUCTION**

The present study attempts to understand family functioning, family resilience and quality of life of substance abusers in de-addiction centres in Aizawl Mizoram. The present study focuses on how substance abuse impacts the quality of life of substance abusers who are in de-addiction centres in Mizoram, their family functioning and family resilience. This chapter focuses on the general introduction of the study including conceptualization of the term family functioning, family resilience, quality of life, substance abuse, family functioning and substance abuse, family resilience and substance abuse, quality of life and substance abuse, a global scenario of substance abuse, Indian scenario of substance abuse, Northeast India Scenario of substance abuse, Mizoram scenario of substance abuse, an overview of the literature and need and significance of the study.

A family is a group of people who live together and are related by blood, marriage, or adoption and residing together; all such people (including related subfamily members) are considered members of one family (Miller, 2014)

Today, in the globe, the family continues to be the key setting for human connections, nurturing, and socializing. Thus, it is important to pay attention to how drug usage affects the family as a whole and its members. Substance abusers have a distinct impact on the family as well as its members through unmet developmental requirements, poor attachment, financial struggles, legal issues, emotional stress, and occasional violent behaviours committed against them.

Studies show inclusion of family in the treatment course of the substance abuser is helpful for the family and the substance abuser. The effectiveness of treating only the person who has an active addiction disorder is constrained. Therefore, social workers have always understood the importance of evaluating the individual within the context of his or her familial situation. As a result, the

importance of the familial relationship between the individual and their environment is emphasised throughout social work practice (O'Farrell & Fals-Stewart, 2000).

Without involving the family and treating only the substance abuser ignores the secondary effects family members face due to the behaviour of the abuser, therefore leaving them vulnerable to other physical and psychological issues. This also dismisses the family's potential to act as an instrument for rehabilitation (Haber, 2000).

### **1.1 Family Functioning**

A family is an essential societal unit whose members agree to take care of one another both physically and emotionally. The agreement is typically made by two or more adults—with or without children—as well as single adults with children—to share resources including time, space, and money. Families typically operate in an environment where there is a sense of belonging. According to Moore (2008), family functioning includes elements within the family such as communication styles, traditions, different duties and boundaries, and the degree of convergence, agility, adaptation, and persistence. Family functioning is described as how the family members interact, react to, and treat other family members. A family goes through an adjustment period whenever they go through stress, adversity, trauma, or a life-changing experience, either positive or negative. The whole family system must adjust and evolve how it functions throughout this adjustment period.

Family Functioning is the patterns of relating or family processes over time A healthy family offers a setting that promotes the successful growth and safety of its members. This result represents a family environment that is safe, harmonious, and mutually supportive. It is defined by appropriate roles, open dialogue, regular expression of positive effects, and one that is founded on a common set of customs and beliefs (Dobkin et al, 2002).

Every member of the family must be emotionally supportive of one another and be able to influence one another's behaviour as it is directly related to the functionality of the family (Moss, Lynch, Hardie, & Baron, 2002). The Circumplex Model of Family Functioning demonstrates the developmental changes a family system goes through in response to a traumatic event or a significant life transition. (Lochman & van den Steenhoven, 2002). Family function is conceptualised along two axes in the Integrated System Model of Family Functioning (Lin et al., 2011): family competency and family style. The ability to manage change over time involves both structure and family competency. *Family style* is categorised as centrifugal or centripetal and refers to the "stylistic nature of family interaction." Centrifugal families look for satisfaction outside the family, whereas centripetal families experience emotive contentment within the family (Botvin & Griffin, 2010).

## **1.2 Family Resilience**

The process of successfully navigating, adhering to, or managing substantial stress factors or trauma is referred to as resilience. This ability to adapt and "bounce back" in the face of hardship is made possible by the assets and resources that an individual has access to within their everyday lives and surroundings. This allows the family to return to previous levels of functioning following a challenge or crisis. Walsh (2016) states that a family is a fundamental institution in society, with a dynamic structure, and it frequently advances, particularly when one of its members is enduring a crisis. Family resilience is the capacity of the family to withstand crises. Resilience is a concept that is explored from various angles. Since the concept of resilience was first presented as a construct at the family level, the viewpoints on resilience have progressed.

According to conventional wisdom, family resilience is the culmination of individual family members' resilience. A progressive viewpoint on family resilience highlights the interconnectedness of the family in its entirety. The perspective also considers the interpersonal dynamics that help families flourish in challenging circumstances. A contrasting viewpoint on the concept views family resilience as both a trait and a process.



Family resilience as a process explains the efficacy of families in their ability to cope with and manage the stressors in their lives, which contributes to the development of family resilience. At the same time, the theory of systems in the family incorporates ecological and developmental viewpoints which are used to construct the concept of family resilience .

### **1.3 Quality of life**

Quality of life primarily refers to how a person evaluates the general "goodness" of various facets of their existence. These assessments cover emotional responses to events in life, disposition, sense of fulfilment and contentment in life, and satisfaction with one's career and interpersonal associations (Cummins, 2005). A simplistic definition of quality of life is satisfaction within multiple life areas (The WHOQOL Group, 1995). Veenhoven (2010) further defined quality of life as the *"individuals' perceptions of their position in life in the context of the culture and value systems in which they live and about their goals, expectations, standards, and concerns"*.

QOL is conceived as an assessment that includes evaluations of a person's life at a specific time, mediated by a multiplicity of objective elements (Campbell et al., 1976, Phillips, 2006; Ventegodt & Merrick, 2003; Verdugo et al., 2005).

The term "quality of life" (QOL) refers to a multifaceted, subjective construct that includes impressions of both the positive and negative (Cummins, 2005; Diener, 1994; Ware, 1987) facets of life at any particular time. Definitions of "subjective well-being" and "subjective quality of life" are not different. The expression of a wide range of human activities, such as challenging experiences, pain, and struggle, as a component of and in response to intellectual pursuits, social interactions, emotional attachment, and mental well-being, can be considered to be engaged subjectivity According to Campbell et al. (1976), a life that is interesting, satisfying, and safe — that is, the goodness of life — is what contributes to a person's overall impression of well-being.

These perspectives, or subjective assessments of life, are at their core an emphasis on the individual's appraisal of their life events and aspirations (Laudet *et al.*, 2009; Veenhoven, 2010). This method provides a different viewpoint from the more typical clinical QOL assessments, where physicians typically concentrate on symptoms and related client/patient well-being (Laudet, 2011). Measures of psychological discomfort, pleasure, and well-being seem to be reliable predictors of the more general notion, of QOL (Constanza *et al.*, 2006; Cummins, 2005; Veenhoven, 2000). In the realm of study on drug use and dependency, this is a relatively recent conceptualization of QOL that is broader than that connected with the evaluation of health-related QOL with its focus on pathology (Tracy *et al.*, 2012).

A general assessment of one's life's satisfaction and impacts (both positive and negative) generates a person's level of well-being (Bowling, 2005; Keys *et al.*, 2002). Happiness is typically viewed as a short-term indicator of how much individuals enjoy their lives (Campbell *et al.*, 1976; Radcliff, 2013), while satisfaction is a more stable indicator of how well a person's needs are met (Veenhoven, 2013). Measures of well-being that complement each other include satisfaction and happiness (Bowling, 2005). Both can be regarded as "democratic" assessments that allow people to assess their own lives rather than relying on proxy judgements made by clinicians and researchers (Diener & Oishi, 2000, Blanc *et al.*, 2014; Hamilton & Redmond, 2010; Lora, 2008; Plege & Hunt, 1997).

Drug usage can have an impact on a variety of aspects of a person's life, including physical and psychological health, social and other ties, and the capacity for employment (Laudet, 2011; De Maeyer *et al.*, 2013; 2010; Fakhoury & Priebe, 2002; Marini *et al.*, 2013; Zubaran & Foresti, 2009). This begs the question of how much drug users gain the advantages they desire. How frequently does this happen if the goal of drug use is to boost one's emotional state?

The use of psychoactive drugs, whether legal or illegal, is common, especially among adolescents and young people (Australian Institute of Health and Welfare, 2011; European Monitoring Centre for Drugs and Drug Addiction, 2014; United Nations Office on Drugs and Crime, 2014; Ventegodt & Merrick, 2003; Gore

et al., 2011; Reavley et al., 2010; Santelli&Galea, 2011). According to Whelan (2004), psychoactive substances such as alcohol, tobacco, cannabis, prescription drugs, and illegal opioids can influence mood, perception, cognition, and behaviour. As a result, they have the potential to either improve or worsen quality of life (QOL).

#### **1.4 Substance Abuse**

The obsessive utilisation of addictive substances disregarding negative repercussions for the user and society characterises substance abuse, as a continuously relapsing condition. Drug and alcohol addiction is a lifestyle trend that is pervasive in both wealthy and developing nations around the world. Consequently, addiction to alcohol, drugs, and smoking is seen as a critical public health issue. Videogames, gambling, sex, and food addictions, among others, have detrimental effects on both the individual and society's health. Drugs that are frequently abused have a significant impact on the neurological system, particularly the brain. While some of these drugs, including opium, marijuana, cocaine, caffeine, nicotine, mescaline, and psilocybin, are obtained from organic sources, others are manmade or designer drugs. Furthermore, while some of these substances, like alcohol and nicotine, are legal, others that are only available with a prescription have the potential to become addictive to individuals with addictive tendencies (National Drug Intelligence Center 2001).

The fact that many addictive chemicals are outlawed in most nations fuels the illegal drug trade frequently linked to criminal activities. When these substances are first used, they cause euphoria, gratification, and a feeling of well-being that can escalate to mental and physical dependence. When a person attempts to stop using addictive substances, withdrawal symptoms occur, which perpetuates the cycle of addiction. Neuronal adaptation with tolerance or sensitization engaged in the effect of addictive drugs is one of the mechanism(s) implicated with the addiction cycle. The availability, affordability, mode of administration, environmental aspects including behaviours that are acceptable in a community, social conditioning, genetic and epigenetic aspects, as well as other factors have all been linked to addiction. Numerous therapy strategies for addiction to drugs and alcohol have been used over

the years. The main obstacle in managing drug addiction is relapse is the return to drug use after a period of sobriety. Regrettably, the efficacy of pharmacological treatment for addiction to drugs and alcohol has been mainly unsatisfying, prompting the need for novel therapeutic targets and ideas. The relationship between genes, epigenetics, and environment has an impact on substance abuse too. Twin studies often indicate a heritable factor in substance abuse and addiction (National Drug Intelligence Center 2001).

### **1.5 Family Functioning and Substance Abuse**

The first foundation that forges a connection between children and their surroundings is the family. Children develop both their minds and their bodies, develop communication skills, pick up basic social rules, and gain insight into the world through their families. Ultimately, their ethics and values are shaped in a certain way. Every family member's actions have an impact on other people's actions. Family is a dynamic system that adjusts to new events, changes in family dynamics, and societal shifts. Despite these adjustments, a family's functioning nevertheless exhibits some enduring traits that influence how parents relate to their kids and vice versa. Most parents have an idealistic view of how their children will develop, and they consider a variety of parenting strategies to help them get there (Lander et.al, 2013).

The family environment has an important effect on a person's psychological behaviour. Family functioning is a concept that explains how family members can advance and foster their physical, mental, and sustainable changes beneficially and positively by obtaining the spiritual and material conditions of their family. Individual drug usage is strongly associated with family functioning. Researchers have concluded that individuals who connect well with members of the family, especially their parents, are less inclined to participate in behaviour problems. A major factor in male substance abuse is family functioning. Also, it has been revealed that a person's illegal substance abuse behaviour is tied to the functioning of their family. Adolescents with high family functioning are less likely to take drugs than their counterparts with poor family functioning. Research on

mediating and moderating effects can more clearly show that independent variables affect dependent variables because the precise mechanism of action in the connection between familial functioning and relapse tendency is yet unknown (Lander et.al, 2013).

When alluding to a form of beneficial resource or a sound internal psychological condition during an individual's development, advancement, and growth, we use the term "psychological capital." Four components constitute psychological capital: hope (individuals can stick to their goals and change how they approach achieving them as required), resilience (individuals can persevere and maintain their efforts to succeed when faced with difficulties or setbacks), and optimism (individuals make positive assumptions about their future and present achievements), and self-efficacy (individuals have trust in their ability to complete difficult tasks).

Family functioning has a considerable positive predictive influence on optimism, as per earlier research. Hope, resilience, and self-efficacy levels in an individual are substantially positively predicted by family functioning. According to family system theory, individuals are impacted by how the family system is functioning. Family members will be in better mental and physical shape the more efficiently the family system functions as a whole. Hence, parents who have a strong sense of optimism are more likely to have optimistic, hopeful children, implying that their children may also have a higher level of psychological capital (Biederman et. al, 2000).

Numerous studies have indicated that substance misuse and a variety of psychological capital are closely associated. Self-efficacy is a strongly undesirable determinant of substance abusers' likelihood to relapse. Hope and optimism play a significant role in making decisions to abstain from substance abuse. Higher levels of hope are associated with increased self-efficacy and withdrawal motivation. Moreover, resilience acts as a defence against substance misuse and substantially reduces the possibility of relapse. In essence, psychological capital and other

mentally healthy resources work as potent safeguards against substance abuse (Lander et.al, 2013).

### **1.6 Family Resilience and Substance Abuse**

Understanding the nature of risk and resilience in families is recognized as the key to preventing and treating drug and alcohol abuse in substance-affected families. This need is a crucial concern as substance abuse is one of the leading issues faced by families and society in the United States. Recent estimates indicate that 8.3 million children live in substance-affected families where parents have alcohol or other drug problems(Hawkins, Catalano, & Miller, 2012).

Parental substance abuse is considered a major factor in child neglect and/or abuse. Children of parents who use drugs or alcohol are three times as likely to suffer from abuse and four times more likely to be neglected than children of sober parents. In the extreme, some children die or experience failure-to-thrive syndrome as a result of their parent's substance abuse. Many simply go without nutrition and other basic survival needs. In addition, children who are physically and emotionally abused and/or neglected are themselves at risk of developing a substance-abuse disorder, thus continuing what is an intergenerational cycle Living in a home where parents abuse substances places children at higher risk of sexual abuse (Hawkins, Catalano, & Miller, 2012).

The intergenerational cycle continues as two out of three women in drug treatment, who have experienced sexual abuse, report that it contributed to their development of a substance-abuse problem. It has been shown that men develop even more severe substance abuse disorders when they have been sexually abused as children. They are more likely to overdose and engage in suicidal binges. There is also an increased likelihood that they will attempt suicide again. Children who have experienced neglect and abuse as a result of a substance-affected parent are at risk for higher rates of dual diagnoses of both substance abuse and mental health issues over their lifetimes (Felitti., et al, 2018).

In addition to the above risks, another effect of parental substance abuse is the genetic vulnerability or "genetic loading" for these children. Children of alcoholics may have altered brain chemistry that makes them more susceptible to the use and/or abuse of alcohol. They are more likely to begin using at an earlier age, and, when coupled with earlier problematic use, there are more indications of a quicker progression toward developing a substance abuse problem. Addressing these issues becomes paramount with high figures of 10% of children under the age of 18 having used illicit drugs in the last 30 days as reported in the National Household Survey on Drug Abuse (Famularo, Kinsherff, & Fenton,2018).

Furthermore, prenatal substance exposure is yet another by-product of parental substance use. Children exposed to drugs and alcohol in this way are a small portion of those children who are affected by their parent's substance abuse, but this can have negative effects on the developing brain of the fetus. While potentially overestimated in the seriousness of the physical and mental deficits reported by the media, the consequences for children prenatally exposed to other drugs do have serious and long-lasting effects. Pre-natal alcohol exposure can cause fetal alcohol syndrome or fetal alcohol effects that have been linked to permanent developmental delays. Maternal alcohol abuse is the most frequent cause of mental retardation. It appears that prenatal alcohol exposure has more severe and long-lasting effects on development, especially intellectual and behavioural consequences. Developmental delays in both cognitive and language deficits or disorders can result from parental substance abuse. Prenatally drug-exposed children are reported to have lower birth weight, lower IQ scores, poor feeding abilities and eating issues, higher health care needs, and some display disorganized attachment issues. Research findings indicate that 10% to 20% of these children receive foster care services at birth, and another 33% receive these services in the subsequent years (Famularo, Kinsherff, & Fenton,2018).

Children who grow up in substance-affected families have a wide range of unfavourable outcomes. They are reported to have more aggressive behaviours,

hyperactivity, sleep disturbances, criminal behaviour, and overall poor socioemotional development. They have poorer developmental outcomes, while usually more in low-normal ranges rather than severe ranges. They display poor indicators in school performance, peer relationships, self-esteem and impulse control. They appear to lack attachment to school or family, which can contribute to isolation, depression and suicidal behaviour. A 20-year longitudinal study indicated that children raised in alcoholic homes are more likely to have marital failures and be unable to support themselves.

Rigorous research is necessary to discover effective interventions for substance abuse prevention and treatment for high-risk children, their families, and their communities. One area of inquiry has been the study of resiliency, including risk and protective factors, risk and protective processes, and risk and protective chains. The study of resilience will work toward developing an understanding of how substance abuse develops and aiding in prevention and treatment approaches. The attractiveness of the protective models is that they are strength-based rather than the previous emphasis on deficit models (Hawkins, Catalano, & Miller, 2012).

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### **1.7 Quality of Life and Substance Abuse**

Quality of life (QoL) is a significant marker and outcome in the management and treatment of chronic diseases, including substance use disorders (SUD). More and more often, subjective patient assessments of results apart from morbidity and mortality and quality of life are used to evaluate the efficacy of chronic disease treatments. The most popular and suitable measurement is (QoL). A patient's quality of life, or QoL, is a subjective assessment of how they feel about their present physical, mental, social, and environmental conditions, to use the World Health



Organization's four key domains..The WHOQOL Group As compared to other medical specialities, the field of substance use disorder (SUD) treatment has recently emphasised and gathered patient quality of life data less systematically. Crucially, patients' subjective evaluations of the effects of SUD and its management may have on their lives are added to QoL measurements. Such measures give the patient the power to decide whether or not their employment situation, health, and family ties, for instance, are satisfactory. QoL measurements may also aid medical professionals in identifying issues that go beyond the details of the condition and aid in improving treatment choices and objectives (Smith.et.al. 2003).

SUD sufferers often rate their quality of life as bad as those with other severe psychiatric diseases and much worse than the general public (Tiffany et. al, 2012). Low quality of life may also indicate a patient's readiness for treatment; qualitative approach studies have revealed that patients are more explicitly interested in improving their quality of life than reducing their substance use (Laudet et.al, 2009). It's interesting to note that SUD-specific factors, such as drug kinds utilised, frequency of use, and duration of problematic use, have not consistently been associated with low quality of life (De Mayer et.al, 2010). Yet QoL also contributes to SUD recovery: Laudet et al. discovered that better QoL after therapy discharge predicted abstinence than conventional SUD traits (Laudet, 2009).In addition to assessing quality of life for its own sake as a subjective indicator of functioning (Tracy et al., 2012), examining and resolving the dissatisfaction with different life domains that reduced quality of life may enhance abstinence outcomes and enable patients to gain access to a wider array of health advantages after treatment (Laudet,2011).

The fact that there are few reliable predictors of QoL indicates how universal this measure is. However, among opioid, alcohol, and polysubstance users, patients with multiple substance addictions, and non-SUD populations, good mental health appears to be a significant protective factor (Laudet, 2011). This may be due to the significant impacts that psychological symptoms and disorders have on a person's life. Exercise can have a positive influence on QoL in healthy, non-SUD groups in

addition to improving mental health. There aren't many studies examining quality of life (QoL) after exercise in the SUD population, and it's unclear how exercise affects QoL. As mechanisms, it has been proposed that comorbid risk factor reduction, mediation of the detrimental effect of chronic physical disorders on QoL, and increased self-efficacy and other psychosocial dimensions. Evidence that suggests exercise plays a role in increasing cessation rate and other substance outcomes, including seeking, reducing depressed and anxious symptoms, and enhancing physical condition has been sparked by interest in exercise generally among the SUD community (Tracy et. al,2012).

Since the 1980s, an increasing interest in the relationship between the social environment and the trajectory of SUD development and treatment, and the intricacies of social determinants has been increasingly investigated. For instance, it seems that the negative impacts of a network of substance users on abstinence exceed both the qualitative and quantitative support offered in that network. Moreover, it seems that social networks have varying impacts on individuals depending on their gender; for instance, women's treatment outcomes are far more adversely affected by substance use across companions and family members than men's. Also, societal factors that put men and women in a vulnerable situation for relapse or treatment dropout differ for each gender. Despite low QoL being another drop-out risk factor (Laude et. al, 2009), social factors' influences on QoL have garnered less research attention. Moreover, it doesn't appear that this relationship has been explored through a gender lens. Therefore, in this study, we discuss the quality of life (QoL) of people seeking treatment for SUD and look into gender disparities in substances, health, and social aspects linked to lower QoL. The ability to direct treatment providers towards more effective and focused patient care will depend on our ability to better understand these characteristics that are additional predictors of successful treatment results (De Mayer et.al, 2010).

### **1.8 Global Scenario of Substance Abuse**

According to the World Drug Report (2021) by the United Nations Office on Drugs and Crime, over 36 million individuals have drug use disorders and over 275

million people used drugs globally in the previous year (UNODC). The report also noted that despite evidence that cannabis use is linked to a number of health and other harms, especially among regular long-term users, cannabis potency had increased by as much as four times in some parts of the world over the previous 24 years, even though the proportion of young people who perceived the drug as harmful fell by as much as 40%.

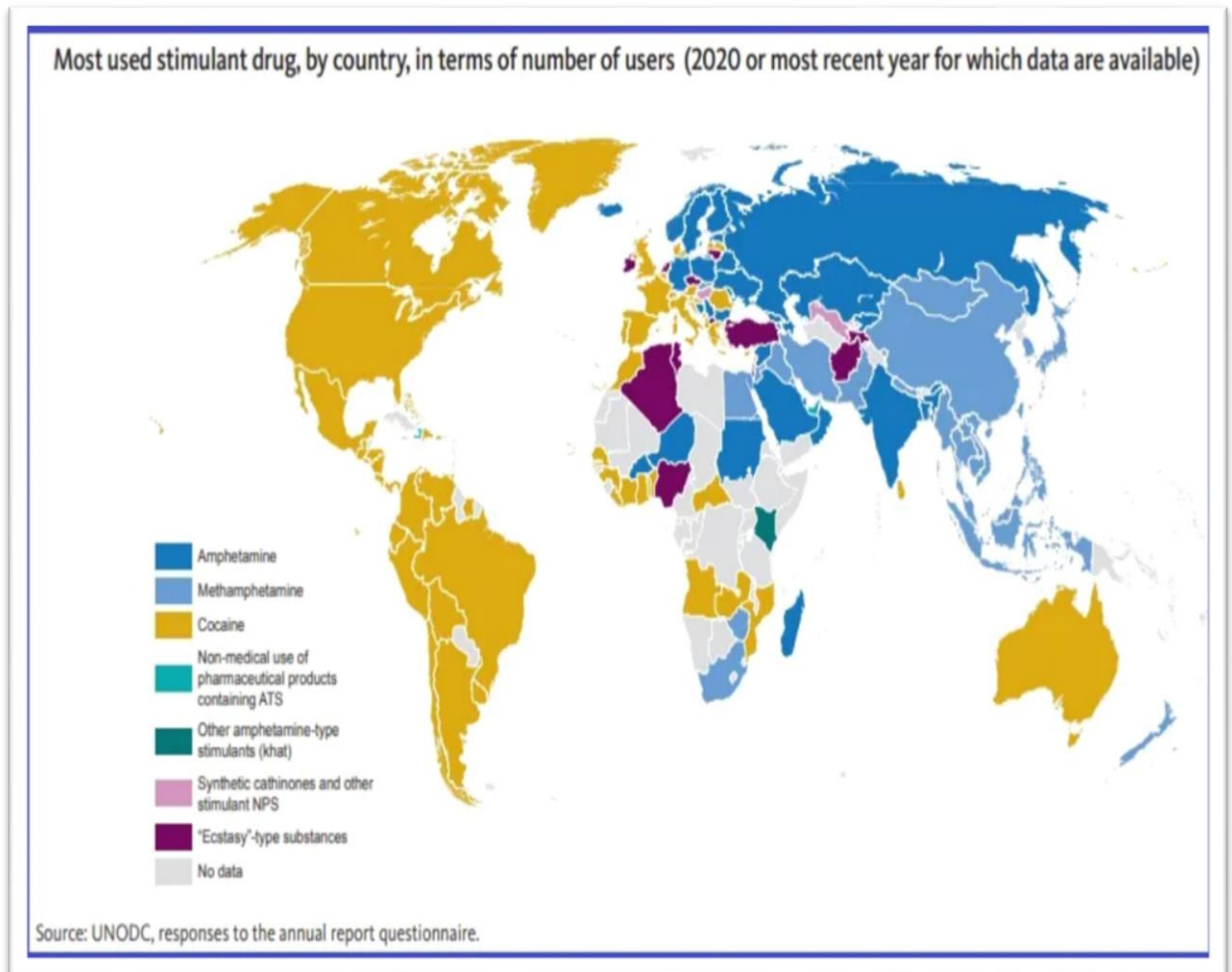
While the percentage of adolescents who believed cannabis to be harmful decreased by 40% in the United States and by 25% in Europe, the primary psychoactive component in cannabis increased from about 6% to more than 11% between 2002 and 2019 and from about 4% to 16% in the United States between 1995 and 2019. In addition, the majority of nations have noted an increase in cannabis use during the pandemic. 42% of health professionals surveyed in 77 nations claimed that cannabis use had escalated. Throughout the same time frame, there has also been an increase in the non-medical usage of prescription medications.

The number of drug users increased by 22% between 2010 and 2019 due in part to the growing world population. According to current forecasts, there will be an increase in drug usage worldwide of 11% by 2030, with a notable increase of 40% in Africa due to its fast-expanding and younger generation. The most recent estimates indicate that 5.5% of people in the world between the ages of 15 and 64 have used narcotics at least once during the previous year and that 36.3 million people, or 13% of all drug users, have a drug use disorder. Injecting medications is believed to be used by approximately 11 million people worldwide, half of whom have Hepatitis C. The majority of diseases linked to drug usage are still caused by opioids. Over the past 20 years, methadone and buprenorphine, the two prescription opioids most frequently used to treat persons with opioid use disorders, have become more widely available. Science-based pharmacological treatment is more accessible now than it was in the past, as evidenced by the fact that the amount available for medical usage has risen 6 times more since 1999, from 557 million daily doses to 3,317 million by 2019. Dark web drug markets were barely established a decade ago, but they currently generate at least US\$ 315 million in yearly sales. While making up a small

portion of total medicine sales, there was a fourfold growth between 2011 and mid-2017 and mid-2017 to 2020, indicating an upward tendency. A globalized marketplace in which drugs seem to be more accessible and available everywhere is anticipated to be brought about by rapid technological advancement mixed with the adaptability and agility of people using innovative products to engage in criminal activities by selling drugs and other substances. This, in return, could lead to faster changes in drug usage patterns and have an impact on public health.

The new analysis reveals that following the first disruption at the start of the pandemic, drug markets have promptly resumed operations. This burst has prompted or accelerated several pre-existing trafficking tendencies across the international drug market. Increasingly big illicit drug shipments, an increase in the use of land and maritime routes for trafficking, a rise in the use of private jets for drug smuggling, and an increase in the utilization of contactless techniques to deliver the drug to end customers are a few of these trends. The ability of drug traffickers to quickly adapt to altered locations and situations has once again been shown by the drug markets' resiliency during the pandemic. The analysis also highlighted how the supply networks for cocaine entering Europe are broadening, driving down costs and raising quality, exposing Europe to additional cocaine market growth. Due to this, the drug's potential for damage in the area is likely to increase. From 163 in 2013 to 71 in 2019, fewer new psychoactive drugs (NPS) entered the market globally. Trends in North America, Europe, and Asia are reflected in this. The results imply that national as well as global control systems, where NPS initially developed a decade ago in high-income nations, have been successful in preventing the growth of NPS (UNODC, 2021).

**Figure1: Global Map of Substance Abuse**



Source: UNODC, Responses to the Annual Report, 2020

### **1.9 Indian Scenario of Substance Abuse**

One of the main issues affecting multitudes of young people in India during the last twenty or thirty years is drug use. In India, a select handful of states and cities have become the top locations for drug use. Although being one of the most industrialised states in India, Punjab in the north has been dealing with an opiate epidemic for an extremely long time. Even our capital city is not falling behind. Other noteworthy states afflicted by the drug crisis include Mizoram, Manipur, Goa, and Mumbai. Youngsters in India abuse narcotics like marijuana, LSD, cocaine,

heroin, and prescription medicines. Other subcategories of medications that are frequently abused include opioids, hallucinogens, and inhalants. Despite being an illegal substance, cannabis, or ganja as it is known in India, is immensely popular. Large-scale, illegal cannabis cultivation and exportation take place. It is consumed locally to some extent. In India, ganja smoking is prevalent among young people, particularly students. It is regrettable to see that India has not received the same level of attention as European nations (Dorabjee&Samson,2000).

The general public is exposed to an extensive range of harsh drugs. Brown sugar, heroin, and cocaine—which were previously unavailable in India—are now readily available in metropolitan cities. Ganja smoking is also increasingly widespread. With the sharp increase in drug addiction, the nation is falling between states of consciousness. Recent reports and research have shown that drug addiction is becoming a greater issue in India, particularly among the younger demographic. Reports state that one adult drug user makes up nearly 74% of Indian families (Burman, 2003).

According to a poll conducted by the Ministry of Social Justice and Empowerment and the United Nations Office on Drugs and Crime (UNODC) in 2019, there are approximately 73.2 million drug users in the country. 8.7 million of the 73.2 million people use cannabis, while 2 million use opiates and other illegal narcotics. Between 17% and 26% of drug users fall into the category of dependent users who require prompt intervention. In India, substance abuse and its effects on women are coming to light more and more. In contrast to the widespread use of legal substances like cigarettes and alcohol, abuse of illegal ones like opiates like opium, heroin, and cannabis is well-known across the nation. The misuse of psychotropic medications and other liquid pharmaceuticals is also becoming more widely known (MSJ&E, 2013).

The Ministry of Social Justice and Empowerment, Government of India, collaborated with the National Drug Dependency Treatment Center (NDDTC) and All India Institute of Medical Sciences (AIIMS), New Delhi, to conduct the National Survey on Extent and Pattern for Substance Use in India. They surveyed all 28 states and 8 union territories of India in partnership with 10 medical institutions and 15 NGOs. With more than 1,500 people working on it between December 2017 and October 2018, it was a significant undertaking (MSJ&E, 2013)

After alcohol, cannabis and opioids constitute the most commonly used drugs; 2.8% of Indians report having used cannabis-related items. While 2.1% of the population uses opioids, 1.14% of the population abuses heroin, 0.96% abuses pharmaceutical opioids, 0.52% abuses opium, 1.08% abuses sedatives (non-medical, non-prescription use), 0.7% abuses inhalants, 0.10% abuses cocaine, 0.18% abuses amphetamine-type stimulants, and 0.12% abuses hallucinogens (Burman, 2003)

Although drug addiction is a threat to the entire nation, certain states are more affected than others. According to the AIIMS data, Delhi, Maharashtra, Uttar Pradesh, Punjab, Haryana, Rajasthan, and Andhra Pradesh are home to more than half of all opioid abusers in India. About opioid use, Sikkim, Arunachal Pradesh, Nagaland, Manipur, and Mizoram have the highest rates. Similarly, the states with the greatest rates of cannabis addiction include Uttar Pradesh, Punjab, Sikkim, Chhattisgarh, and Delhi. Yet, the top five states with the highest sedative use rates are also Uttar Pradesh, Maharashtra, Punjab, Andhra Pradesh, and Gujarat. The study demonstrates that Maharashtra, India's North and North East, and other states suffer from a serious drug usage problem (Dorabjee&Samson,2000).

The United Nations conducted a study on drug use in India over ten years ago. According to the survey, the majority of Indians first experienced drugs when they were still very young (under the age of fifteen), particularly with drugs like alcohol and cannabis. The average age of drug users was around 35, and nearly all of them were men (nearly 95% of them). On the Magnitude of Substance Abuse (2019) survey, the country today has drug users as young as 10 and as old as 75.

Furthermore on the rise is the number of female substance abusers. These figures are extremely concerning considering that India is a young nation (UNODC, 2021)

### **1.10 North East India Scenario of Substance Abuse**

India's North-East region is heavily affected by drug usage. In addition to the increased prevalence of alcohol usage, young people have started abusing other psychoactive substances including heroin and brown sugar, which is a tampered version of heroin. The top three states are Nagaland, Manipur, and Mizoram. Addicts often turn to prescription medicines instead of heroin because they are more affordable and accessible. Drugs classified as "pharmaceuticals" are those that are made to treat illness but are also used in large dosages to induce a high. The most popular medications include cough syrups and painkillers like proximal, pethidine, etc. The younger generation has started using narcotics by inhaling dendrite, fuel, etc (UNODC, 2021).

At Myanmar's border, the north-eastern Indian states of Manipur and Nagaland are marked by armed civil insurrection, intense military presence, and significant unemployment. They make up 0.4% of India's population yet represent 3.0% of all AIDS cases in the country, according to the Indian National AIDS Control Organization (NACO), which classifies them as high HIV prevalence states. In both states, injecting drugs—most frequently heroin and Spasmo-Proxyvon, a synthetic opioid analgesic—is a severe public health issue. In this area, intravenous drug use is a significant means of HIV transmission.

In the northeastern part of India, the majority of the 50,000 injecting drug users (IDUS) are in Manipur, Nagaland, Mizoram, and Meghalaya, according to the National Aids Control Organization (NACO-2006). Alcohol is the substance that is most frequently abused in every state in India, except Mizoram, according to the United Nations Office on Drug and Crime (UNODC) study from 2021. Clients of treatment facilities in Assam, Meghalaya, and Tripura, states in the northeast, primarily seek assistance for issues with alcohol misuse. Alcohol drinkers are the second-largest group seeking treatment services in Nagaland and Mizoram behind



opiate addicts, even though the sale of alcohol is forbidden in Manipur. It is important to note that, in contrast to heroin, the preferred opiate for injection in Mizoram has been associated with a greater probability of abscesses, non-healing ulcers, and amputations, raising the morbidity of drug users.

### **1.11 Mizoram scenario of Substance abuse**

One of the largest drug-related crises in Mizoram's history is currently occurring. Mizoram is located on India's eastern border with Myanmar. For the past 20 years or more, drug addiction has been widespread in the majority of Northeastern states, and it has been progressively spreading throughout the entire region. A recent survey found that drug addiction has been on the rise in Mizoram, where there have been over 1,400 drug-related fatalities since 1984. In Mizoram, Proxyvon/Parvonspas was the fatal drug of choice, followed by heroin. But, in the current scenario, heroin has taken the role of Proxyvon as the principal lethal substance.

Drug misuse and addiction have reached worrisome heights in Mizoram. According to state Excise and Narcotics department records, the state of Mizoram reported a record amount of drug-related fatalities in 2004 with 143 people passing away from addiction. In 2017, at least 65 people, including 12 women, succumbed to drug abuse. According to records kept by the Mizoram government's Social Welfare Department, more than 300 persons died in 2018 as a result of drug addiction.

The Mizoram Police, Mizoram Excise Department, and NGOs that cross the border from Myanmar often seize the majority of the narcotic substances that are brought into the state. In Mizoram, about 25,000 individuals, largely young people, use drugs, mostly marijuana. The bulk of them share needles and syringes while consuming heroin as IDUs. As a result, 70% of IDUs contracted HIV. The Mizo society of today is very different from that of the past; families are increasingly becoming nuclear in urban areas as both parents work, making it difficult for them to give their children quality time; moral values are now placed less value in families; elders are neglected; and children frequently look outside of their households for

someone with whom to communicate and express themselves, which can occasionally result in dangerous behaviour (MSJ&E, 2013).

In poor families, due to extreme poverty, parents and children are all involved in working to make ends meet. There is no money or time to pursue education, and as a result, illiteracy leads to involvement in unethical behaviour and the company of unsavoury characters. Modern education systems have also placed a lot of pressure on students. Younger folks experience a profound sense of alienation in these situations; they lose their knowledge and desire to relieve themselves of their worries, tensions, and melancholy, which finally leads them to use drugs or other addictive substances. They feel much better in the numbing brought on by the drugs than they do in the strain brought on by their daily life. They believe that substances allow them to forget all of their anxieties and worries and leave them feeling free and trouble-free. (MSJ&E, 2018).

Baseline Study on Extent and Pattern of Drug Usage in the State was done in 2017 by the Department of Social Welfare, Government of Mizoram. The survey uncovered numerous startling statistics concerning drug users in the State. The survey involved surveying 2633 drug users with an average age of 28 years throughout all eight of Mizoram's districts. 80 percent of the 2,633 substance abusers interviewed were men. According to the study, the majority of drug users claimed to have started using between seven and twelve years after beginning school, and the majority of them smoked before taking drugs. According to the report, heroin, sedative drugs, and inhalants are the most frequently abused substances in Mizoram, second by pharmaceutical opioids (volatile solvents). Also, the poll found that among the drug users interviewed, 49.5% were unmarried and 24.2% were divorcees. An additional 20.7% of substance abusers were married. Three-fourths of the substance abusers still resided with their parents, it was also discovered. 786.6% of injectable drug users claimed that their friends had first introduced them to the substance, and 658.8% of these users admitted to sharing needles with their friends. The study also reveals that dextro-propoxyphene and heroin users experienced overdoses at rates of 47% and 47%, respectively (like spasmo-propoxyvon and parvon spas). In order to

combat youth drug addiction, the poll also stressed the significance of educating youths and discouraging them from using narcotics at a young age (MSD&RB, 2017).

As recorded by MSD & RB (2024), there are 27 De-addiction centres with 2758 bed capacities and 2381 inmates in Aizawl district.

### **1.12 Overview of Literature**

To ascertain the connections among family functioning, family resilience, a person's quality of life, and the kind and pattern of drug use, a study of the literature has been done. The research's general conclusions are presented below:

- Family resilience, a crucial component of quality of life, could be utilised to forecast a person's general level of well-being.
- The bond between parents and children, social support, family dysfunction, and family types are all factors that affect quality of life.
- Family functioning may or may not be a significant factor in determining one's quality of life.
- Several measures were used to gauge quality of life. Using different techniques for evaluating the quality of life may lead to inconsistent results about the causes and determinants of quality of life.
- Families affected by substance abuse experience a tidal surge of rage, frustration, anxiety, and isolation.
- The ongoing issue caused by a family member's substance abuse affects nearly every element of how the family functions.

Whether family functioning affects the quality of life is a contentious issue. There is a significant correlation between total family functioning, family resilience and quality of life. However, when focused on cohesion, some scholars believe that cohesion can be a factor in determining quality of life. Some do not. The quality of life was found to be substantially correlated with family cohesion, Family cohesion and quality of life, however, are unrelated by others.

When it comes to children with substance abuse, their families may not have a big impact on their quality of life, which could explain the gap. If there is a connection between cohesion and quality of life, more research on varied populations is required. There is a need for greater study on family functioning, family resilience, and quality of life given the lack of accessible studies. There is a lack of studies that look at the quality of life, family resilience, as well as the family, even though there is a wealth of literature and research on these subjects.

### **1.13 Statement of the problem**

Drug misuse is a worldwide issue. There is a universal use of drugs in one way or another. According to estimates, between 167 and 315 million persons between the ages of 15 and 64 used an illicit substance in 2010. In India, alcohol and drug abuse has become a major problem. The country is extremely exposed to the problem of drug abuse due to its geographic location. India has evolved from only being a location for the passage of such narcotics from the "Golden Triangle" or "Golden Crescent" to one that also consumes them (MSJ&E, 2013). Due to their geographic location and other considerations, the northeastern states of India were particularly susceptible to high rates of substance misuse.

It is simple to imagine how drug addiction impacts the substance user. With continued addiction, the effects only worsen. There may be both short-term and long-term health problems, job loss, escalating financial difficulties, and legal issues. Addiction is a difficult condition to live with. The effects are felt by many people, not just those who battle addiction. Beyond the use of narcotics, active addiction has far-reaching impacts. The immediate family is also impacted when a loved one struggles with drugs or alcohol. Addiction affects everyone who loves the addict, whether they are a child, parent, or spouse.

The effects of addiction on the entire family are numerous. Which member of the family is experiencing the difficulty will determine the precise effects. Everything is at stake, including safety, finances, and relationships. Children who have a parent with an addiction issue receive less help and direction as they mature.

On the other hand, parents of substance-abusing kids have unique challenges. Children having siblings with a problem while growing up also struggle. Even the addict's spouses endure severe impact.

The impacts of drug addiction on families are innumerable. Relationship tension, money problems, and a higher likelihood of domestic violence are just the beginning. Not many families experience the same effects to the same degree since every family has a unique dynamic. Whatever the case, it is indisputable that addiction has an impact on every member of the family. Relationships are strained by addiction, regardless of which family member is struggling. Whether it is a parent, child, spouse, or sibling does not at all matter. To some extent, every member of the family battles alongside the addict. Everyone person in the home faces a daily battle when living with someone who is an active addict.

#### **1.14 Need and Significance of the Study**

The present study is useful for various institutions like De-addiction centres, Faith Based Organizations (FBO) working for substance abusers, Family Counselling Centres (FCC) educational institutions and youth civil societies like YMA, MSU, MZP etc. The study serves for policymakers to make policies to appoint professional Social Workers in government-aided Centres through the Ministry of Social Justice and Empowerment.

The family is a dynamic system that must accomplish goals and objectives in order to carry out routine daily chores. In this way, the family may be held accountable for any abnormal behaviour and suffer as a result. Because addictive behaviours are so complicated, dealing with them requires multifaceted strategies. This study could be useful for clinical professionals and families to deal with issues more effectively if they have a thorough awareness of the family's role in addictive illnesses.

Family is crucial in the emergence, maintenance, and recovery of addictive behaviours. The factor may vary depending on the population and stage. Moreover, a thorough understanding of sociocultural effects is necessary. This study could be

helpful for families to allow their members the flexibility, room, and stability they need to develop and flourish in all aspects.

Families typically change roles and activities, and relationships are adjusted. As substance use advances from use to abuse and possibly addiction, this study could help in the battle for balance or homeostasis within a family.

### **1.15 Conclusion**

In this chapter the concept of family functioning, family resilience, quality of life, substance abuse, substance abuse and family functioning, substance abuse and family resilience, substance abuse and quality of life, the global scenario of substance abuse, Indian scenario of substance abuse, Northeast India scenario of substance abuse, Mizoram scenario of substance abuse and an overview of the literature. The prevalence of substance abuse and its impact on the family can be understood from this chapter.

The next chapter discusses the review of literature which is an essential component of the study.

## **CHAPTER - II**

### **REVIEW OF LITERATURE**

A brief introduction of the present study and the basic concepts has been discussed in the previous chapter. A review of the literature is an essential component of a research study. The present chapter discusses drugs and their effects, studies on family functioning, and studies on family resilience and quality of life. The present selection includes various studies done by researchers across the world which are relevant to the present study.

#### **2.1 Drug and its types**

##### **1. Drug**

Drugs are chemical substances that alter the way the human body works. It can enter the body orally or through the nose, skin, or veins and travel through the bloodstream to every part of the body. It can also affect the brain in ways that can enhance or dull sensations, change attentiveness, and occasionally even lessen physical pain. The dosage, frequency of usage, time it takes to reach the brain and whether or not additional foods, medications, or substances are consumed concurrently all affect the drug's or substance's effects. Therefore, drugs can be thought of as a chemical that modifies the rate at which cells function. It should be emphasised that many drugs have dual effects. For instance, alcohol has stimulant and depressant properties, whilst ecstasy has stimulant and hallucinogenic properties (SANCA, 2004).

According to Balogun (2006), it is also seen as a substance that alters perception, cognition, emotion, behaviour, and basic bodily functioning. Thus, they may be viewed as chemical modifications of living tissues that could result in alterations to behaviour and physiological processes. Drug use has historically been associated with magical-religious rites, festivals, and social gatherings. Their use spread gradually to new contexts. Some of these substances, like tobacco and cannabis, have a natural origin. Others come up as a result of chemical processes that

use natural resources, such as the production of alcoholic beverages from the process of distillation or fermentation of fruit juice or grains. Artificial means are also used for manufacturing drugs. This is true for synthetic pharmaceuticals as well as medications used for mental health (Nnachi, 2007).

## **2. Classification of Drug**

Drug classification has been done using a number of factors. Drugs are divided into legal (such as alcohol, cigarettes, coffee, hypnotics, sedatives, inhalants, etc.) and illicit (such as opiates, cannabis, cocaine, synthetic drugs, hallucinogens, etc.) categories based on their conformity with the law. There has also been a distinction between soft and hard drugs, albeit it is today rarely utilised due to their limited utility and the potential for creating the false impression that so-called soft drugs are not harmful to health. The impact on the central nervous system (CNS) is a further categorization criterion (Australian Institute of Health and Welfare, 2014).

A typology that differentiates between medicines that are CNS depressants, stimulants, and perturbers was proposed by Abrahamsson et al (1987). Alcohol, opiates, and psychotropic medications like hypnotics, anxiolytics, and antipsychotics are included in the first group. The second category includes mood enhancers (antidepressants), large alertness stimulants (like amphetamines and cocaine), mild alertness stimulants (like coffee and nicotine), and both. Hallucinogens, cannabis, synthetic drugs, and solvents (such as glue, adhesives, etc.) make up the third category of drugs, which also includes psychedelic substances.

## **3. Drug Use Definition**

The majority of commonly consumed psychoactive substances are in the forms of alcohol, tobacco, cannabis, prescription and over-the-counter pharmaceuticals, and illegal opioid use.

All of these substances have the potential to affect mood, perception, cognition, and conduct (Whelan, 2004). Numerous categories can be used to classify



psychoactive substances. They could be categorised based on how they affect public health.

The National Health and Medical Research Council (NHMRC,2009) has established what alcohol intake is considered low-risk and dangerous. These recommendations state that healthy male and female people may consume alcohol at low risk over the short term (no more than four glasses) or at ‘risky’ levels (five or more glasses) during any given session (NHMRC, 2009).

As an alternative, drugs can be divided into licit and unlawful categories based on their legality. For instance, most people believe alcohol to be a licit (i.e. legal) drug, whereas most people consider cannabis to be an illicit (i.e. criminal) drug. They may additionally be classified according to their “*appropriate use*” or “*misuse*” according to the eighth definition. One example is the ongoing discussions about appropriate medicine administration. However, depending on whether or not a medicine has been taken as prescribed or in accordance with the written instructions, it may have been “used appropriately” or “*misused*”. There isn’t a universally accepted definition of what constitutes “misuse” of a prescription. Another term for drug abuse that is not by a doctor’s prescription (or specified dose) is “extra-medical” medication use (De Maeyer et al., 2010).

Depending on its derivative, such as opioids, the same medicine may potentially be handled differently. Heroin is listed as a prohibited substance under the Therapeutic Governance Authority’s Australian Standard for the Uniform Scheduling of Medicines and Poisons. Other opioids, like morphine and methadone, are classified as prohibited substances and need permission from the government to be prescribed. Another strategy is to classify drug use based on the way that particular drugs are taken. Drug users are frequently classified according to whether or not they inject narcotics. For instance, respondents to polls are frequently asked, “*Do you inject?*” alternatively, “*Have you ever/recently injected?*”? Participants in the study are then classified as “injectors” or, more frequently, “people who inject drugs” (PWID), or not (NHMRC, 2009).

#### **4. Alcohol and Tobacco**

The most often used substances worldwide are alcohol and cigarettes. The World Health Organisation (WHO) reports that 8.3% of people in the world who are 15 years of age or older had drunk alcohol in the previous 12 months. Around 16.0% of drinkers in the world who are 15 or older regularly engage in excessive episodic drinking (WHO, 2014a). According to the WHO (2014), excessive episodic drinking is defined as consuming six or more standard drinks (or 60 grams of alcohol) on at least one occasion each month. Complex socio-demographic, economic, and cultural factors support alcohol usage. Additionally, prevalence is typically higher in wealthy than in underdeveloped nations. Even though women are typically less prone to drink than men, young adults consume more alcohol than older persons.

#### **5. Cannabis**

According to the European Monitoring Centre for Drugs and Substance Addiction (2010) and the United Nations Office of Drugs and Crime (2014), cannabis is the most popular illegal substance in the world. According to Whelan (2004), there are between 125 and 203 million cannabis users worldwide. According to the United Nations Office on Drugs and Crime (2014), between 2.7% and 4.9% of people in the world between the ages of 15 and 64 had used cannabis in the last year. The incidence of cannabis use varies significantly between nations, though. The prevalence rates in West and Central Africa, North America, and Oceania are significantly higher than the worldwide average, according to the World Drug Report (United Nations Office on Drugs and Crime 2014). Between age groups, cannabis use varies in frequency. For instance, according to the European Monitoring Centre for Drugs and Drug Addiction (2014), 1% of adults in the European Union aged 15 to 64 have used cannabis weekly or more frequently, down from 22% who have used it at least once in their lifetime.

## **6. Medications**

‘*Misuse*’ of medications is a relatively recent problem. In comparison to other medications, the epidemiological data are very scarce. Research commissioned by the United Nations Office on Drugs and Crime has stated that “existing 11 available informations about the non-medical use of prescription drugs is insufficient to estimate the scale of the problem with accuracy” (Fischer & Rehm, 2007). More and more people are becoming aware of how common it is to misuse both over-the-counter and prescription medications. Particularly in Canada, the US, and Australia, this is true. Concern in these nations centres on how frequently opioids are prescribed for long-term non-malignant pain. Use of Illegal Opioids: Opioids can be used illegally, against medical advice, or without a prescription, as is the case with heroin (United Nations Office on Drugs and Crime, 2014).

**7. Impact of Substance Abuse:** According to Fischer & Rehm (2007) the impact of substance abuse is as follows:

### **i) Harms**

The use of psychoactive drugs has the potential to do great harm to both the individual and the community. Harms can happen to anyone using drugs, even infrequent users, and they cannot even be noticed by the authorities. One example of this is when a user misses work or school due to their drug usage. However, statistics are gathered on certain harm indicators for use in policy and intervention. The most often reported indices of the harm caused by alcohol and other drugs are mortality, disease burden, interaction with health services, and dependence.

### **ii) Dependence**

According to the United Nations Office on Drugs and Crime (2014), there were between 16 and 39 million drug addicts globally. Drug dependence may have an impact on most aspects of life, including physical and psychological health, social roles and connections, employment opportunities, and personal safety and welfare. Dependency is clinically described by the DSM-IV as a “*cluster of cognitive,*

*behavioural, and physiological symptoms indicating that the individual continues to use the drug despite significant drug-related problems*". Approximately 3% of people worldwide (6% of men and 1% of women) have an AUD.

### **iii) Comorbidity**

Comorbidity is the co-existence of two illnesses, most frequently a substance use disorder (SUD) and a mental health problem (MHD). Comorbidity affects dependent people quite frequently, presumably as a result of similar underlying causes. According to estimates from Teter et al., (2005), 3.6% of adult Australians have both an SUD and an anxiety illness, and 1.4% of adult Australians have both an SUD and an affective disorder. Even non-dependent drug users may endure psychological anguish. Not all psychological distress, nevertheless, will be related to drug use. According to data from the 2010 NDSHS, smokers are twice as likely as non-smokers to have had a mental health diagnosis or treatment, as well as to have felt high or extremely high levels of distress. In comparison to irregular cannabis users, recent cannabis users additionally expressed higher levels of psychological distress (AIHW, 2011). Distress, however, does not appear to be a constant across medication effects. When compared to recent drinkers, those who refrain from alcohol are more likely to experience severe or very high psychological discomfort (AIHW, 2011).

## **8. Chemical Basis of Pleasure:**

There seems to be a physiological or psychological basis for the enjoyable effects that drugs provide, based on the clinical characteristics of each of the medications that are the subject of this thesis.

### **i) Alcohol**

Alcohol comes in countless varieties (Inaba & Cohen, 2007). According to Rang (2011), alcohol is a depressant in theory. Low to moderate intake of alcohol is frequently accompanied by feelings of warmth, minor drowsiness, and relaxed muscles. According to Inaba and Cohen (2007), it reduces inhibitions, boosts self-

assurance, and encourages sociability. After the first few drinks, drinkers frequently describe feeling euphoric (Baker-Dennis & Pryor, 2014).

## **ii) Tobacco**

The main component of tobacco, nicotine, has a variety of impacts on the body (Julien, 2001). According to Rang et al., (2011), nicotine is a stimulant that causes neuronal excitation as well as desensitization. Julien (2001) states that nicotine is quickly absorbed by the body and increases psychomotor activity, cognitive function, sensorimotor performance, attention, and memory consolidation.

## **iii) Cannabis**

Tetrahydrocannabinol, which increases dopamine synaptic levels and dopamine neuronal firing in the reward circuit of the brain, is thought to be responsible for the physiological and psychological appeal of cannabis (Baker-Dennis & Pryor, 2014). Cannabis is frequently used to improve well-being, facilitate pleasure, and facilitate mood enhancement (Becker, 1953; Hirsch et al., 1990; Hallstone, 2002; Harris et al., 2000; Green et al., 2004; Hallstone, 2002; Hammersley et al., 2001; Santelli & Galea, 2011).

## **iv) Medications**

According to Fisher & Rehm (2007) and Cooper (2013), medications are typically used to manage sickness symptoms as well as to reduce pain, increase mobility, and improve everyday functioning. In order to treat psychosomatic pain, medications may also be used outside of the specified dosage (Zullig & Divin 2012). They are utilised as a reaction to psychological anguish rather than the underlying sickness (Johnston 2009; Zullig and Divin 2012). According to McCarthy et al., (2005), young individuals who use medication in this way may also be doing so to address their physical suffering. Young adults may take additional prescriptions for health issues and maladies for which they have not seen a doctor or other healthcare provider, according to several researches on life satisfaction and young adults (Chen, Cohen et al., 2004, Zullig. et al., 2007).

Additionally, drugs are sometimes misused for amusement. According to cross-sectional surveys of college students in the US, friends are the most likely to use non-prescribed medications for a variety of different reasons (McCarthy et al., 2005). These include increasing alertness and focus getting drunk (McCrathy et al., 2005, Arria, Caldeira et al., 2008), and sensation seeking (McCrathy et al., 2005, Arria, Caldeira et al., 2008).

#### **v) Opioids**

Opiates can cause flushing and a highly euphoric, diffuse physical sensation that has been compared to an orgasm, especially when injected or snorted (Baker-Dennis & Pryor, 2014). After the initial rush, one feels content. Examining use from the user's point of view is essential to the pursuit of enjoyment with lay information being at least as significant as epidemiological data (Hunt et al., 2007). 'Pleasure', on the other hand, refers to the advantages of drug use. A more comprehensive strategy is required that takes into account both the potential for damage and the positive aspects of drug use and pleasure. Consideration and evaluation of drug users' quality of life offer a more insightful viewpoint (Moore, 2008; O'Malley & Valverde, 2004; Pennay & Moore, 2010; Valentine & Fraser, 2008).

### **9. Drug Addiction**

Addiction is a long-lasting, frequently relapsing brain disorder that results in obsessive drug seeking and use, despite negative effects on the addict and those around them. The majority of people choose to use drugs voluntarily at first, but as the brain changes over time, it becomes more difficult for a person to maintain self-control and withstand strong urges to use drugs (Azmitia, 2001).

Many people don't comprehend the causes of or processes involved in drug addiction in others. It is a common misconception that drug users lack moral fibre or willpower and that they can simply decide to stop using drugs by altering their behaviours. Truthfully, substance abuse is a difficult condition that requires more than just good intentions to overcome. Even for those who are prepared to stop using

drugs, quitting can be challenging because drugs alter the brain in ways that encourage compulsive drug use (United Nations Office on Drugs and Crime, 2014).

When dependence appears, which is described as a collection of physiological, behavioural, and cognitive characteristics in which the use of a drug becomes an essential need for the individual, drug use turns into abuse. This phrase is frequently used about tolerance or the requirement of ingesting more of a substance to experience the effects of earlier intake. A dependent person experiences withdrawal syndrome when they stop consuming (Azmitia, 2001).

The occurrence of severe physical discomfort (tremors, chills, sleeplessness, vomiting, pain in the muscles and bones, etc.) when drug use is terminated is a sign of physical dependence, which is a condition of adaptability of the organism to the presence of the drug. When the substance's activity on the body is influenced by medications intended to inhibit its effects, the same physical discomfort manifests (Azmitia, 2001).

When a person feels an emotional need for a drug despite not having a physiological need for it, they may feel compelled to use it frequently to satisfy that desire, feel good, or avoid discomfort. This condition is known as psychological dependence (Office on Drugs and Crime of the United Nations, 2014).

## **10. Effects of Drugs**

Drugs alter a person's neurological functioning by acting on the central nervous system. The neural receptors, which are structures within a neuron or in its membrane and are characterized by selective binding to a substance and the physiological effect that follows the union, are the first parts of the body to be affected by a chemical.

## **11. Substance misuse as a mental health disorder**

Since the 1930s, when Alcoholics Anonymous was founded, substance or drug abuse has been seen as an illness that may be treated. Before that, various kinds of drugs were often misused, but not considered diagnosable, treatable health disorders. Drug misuse is categorized through the Diagnostic and Statistical Manual (DSM) (American Psychiatric Association [DSM-IV-TR], 2000) under two basic categories: abuse and dependence. According to the DSM, substance misuse exhibits the following patterns: failure to meet significant role obligations, substance use in potentially dangerous contexts, legal issues, and enduring interpersonal or societal issues. The DSM defines substance dependence as having the following patterns: greater usage of the substance; diminished effect with the same amount of substance use; recognisable withdrawal symptoms; substance use to ease or prevent withdrawal symptoms; higher doses of substance use over a longer period; futile attempts to cut down or control substance use; a significant amount of one's time engaged in activities to obtain the substance; use the substance or recover, and continuing substance usage despite having ongoing medical or mental issues that the substance has either caused or exacerbated. According to the study's definition of drug misuse, using any form of drugs to the point where one might be given a DSM-IV-TR diagnosis of drug abuse or dependence.

There are now more treatment choices available for people who misuse drugs because of the development of DSM classifications. Although not all treatment models are supported by solid theory, researchers have worked to create theories that can clarify the addiction process to more effectively create treatments that target those underlying processes. The moral, socio-cultural, psychological, illness, neurological, and bio-psycho-social models of addiction are the most often utilised ones (Fischer & Rehm, 2007).

## **12. Models of addiction**

The moral, socio-cultural, psychological, illness, bio-psycho-social, and neurological models of addiction are six of the more prevalent ones. The moral



model emerged as the first theory to explain drug addiction (Fisher & Harrison, 2013). The moral model of drug abuse states that each person makes personal decisions, and addiction is a result of those decisions (Fischer & Rehm, 2007). According to Fischer & Rehm (2007), the sociocultural model of addiction focuses on external influences on addiction such as culture, religion, family, and peers. According to the psychological model of addiction, psychological issues including emotional distress drive people to take drugs to cope with suffering and are therefore secondary to drug use (Fischer & Rehm, 2007). In this paradigm, some people have addictive personalities, and using drugs to relieve pain can lead to undesirable behaviours of habitual drug use. The disease model of addiction states that addiction is a primary disorder that cannot be treated as a secondary condition. This approach focuses on abstinence as the only acceptable treatment objective because the condition is chronic and incurable. According to the medical concept, chemical changes in the brain are the main cause of addictions. This is one of the factors cited by professionals as to why recovery rates from addiction are so poor. The biological, sociocultural, psychological, cognitive, environmental, and developmental perspectives are all included in the bio-psycho-social model of addiction, which explains addiction (Fischer & Rehm, 2007).

### **13. The cycle of addiction**

These models might make it easier for us to comprehend why certain people get caught in the “*cycle of addiction*”. According to research, done by McCubbin et al., 2001, addiction is a recurring, chronic illness. In essence, many people who abuse drugs or alcohol find themselves locked in a cycle of relapse and recovery. The concept of “*cravings*,” or the impulse or want to take a substance, has been the subject of much research. Researchers concur that cravings are “*at the heart*” of client relapse even though the craving construct is a difficult and dynamic process. Three basic theories for cravings have been the subject of research: biological, emotional, and cognitive aspects. According to scientific models, addiction is a “*brain disease*” and its aetiology arises from neurobiological processes.

According to emotional models of addiction, addiction happens as a result of trying to avoid bad emotions like stress. According to cognitive models, cognitive processes like the cravings brought on by viewing an image of a person drinking alcohol are entrenched with addictions. Withdrawal is referred to as “a substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy or prolonged” in the DSM. Such symptoms as hyperactivity, hand tremors, sleeplessness, nausea, vomiting, hallucinations or illusions, psychomotor agitation, anxiety, and seizures are all associated with alcohol withdrawal. The process of stopping drug misuse can be a drawn-out and labour-intensive procedure since withdrawal from drugs can be agonising both emotionally and physically. Before the relationship is fully ended, this process may involve multiple instances of relapse and rehabilitation. Alcoholics Anonymous (AA) is one organisation that contends that recovery is a continuous process and that an individual’s attachment to a substance can never truly be broken (McCubbin et al., 2001).

#### **14. Substance Abuse Treatment**

Treatment involves a single service or a combination of therapies and services. No one treatment is suitable for everyone. Services and treatment should be tailored to the individual’s issues and requirements. Effective treatment addresses all of the patient’s needs, not just his or her drug usage. In addition to addressing chemical addiction, problems with mental health, social issues, employment, and the law must also be addressed. Treatment levels might range from outpatient to inpatient hospital-based to day treatment to short and long-term residential programmes. Some patients need detoxification and stabilisation before starting treatment. To overcome treatment-related obstacles, other people might require outreach services (Arria et al., 2013).

Assessment and treatment planning are on a partial list of treatment services prescriptions for specific medicines, such as methadone and buprenorphine for heroin addiction or misuse for alcoholism. Crisis management and case coordination between the treatment provider, the child welfare agency, and other required services Psychotherapy and counselling for individuals and groups recovery from drug and

alcohol abuse education, medical diagnosis, and treatment Diet, physical activity, acupuncture, and other unconventional services Mental health services and self-help organisations such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) that follow a 12-step programme. According to Thomas & Corcoran (2001) additional specialised treatments may address violence in the household, mental disorders, childhood trauma, drug misuse, HIV/AIDS, or other problems related to the parent's substance abuse.

Treatment times can last anywhere from a few weeks to months to several years. The degree of the addiction, the drugs used, the support networks available, the patient's personality, and other related behavioural, physical, or social issues are what define the type, length, and degree of therapy. It's critical to consider treatments as the management of a chronic illness, like diabetes or high blood pressure, as opposed to crisis intervention, like urgent care for a broken limb (Fischer & Rehm, 2007.).

## **15. Drug misuse treatment**

There are various drug misuse treatment methods and techniques to aid persons who struggle with substance abuse, many of which are based on the models of addictions (Arria et al., 2013). Mutual-help groups, cognitive-behavioural therapy, motivational interviewing, contingency management, medication, and family therapy are some of the most often-used types of therapies or interventions (Thomas & Corcoran, 2001). Mutual-help groups, also referred to as twelve-step programmes like Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), are one of the most well-liked therapies (Fisher & Harrison, 2013). The disease model that these mutual aid groups typically use suggests that addiction is a disease and that one is constantly "recovering" from the disease.

Although there are twelve-step programmes all over the United States, cognitive-behavioural therapy (CBT) and motivational interviewing (MI) are treatments that are frequently utilised in outpatient and inpatient treatment settings (Walters, 2012). The foundation of cognitive behavioural therapy (CBT) is the idea

that human behaviour is mostly learned rather than genetically inherited and that one can employ the same method of learning that leads to the problem to solve it. Motivational interviewing is founded on the notion that people who abuse drugs are ambiguous about transformation and that questioning can be utilised to help people understand and overcome their ambivalence. Another common form of therapy is contingency management, which aims to boost reward from healthy options while decreasing reinforcement from drug use, especially in situations where drug use is incompatible. Modern medical advances have demonstrated the efficacy of combining psychotherapy and pharmaceutical drugs. But as of right now, only alcohol withdrawal and opioid addiction are treated with prescription drugs. Family therapy methods that address substance abuse are currently becoming more prevalent Walters (2012),.

Behavioural Couples Therapy, Brief Strategic Family Therapy, and Multidimensional Family Therapy are only a few examples of family therapy models with empirical support for their efficacy in treating drug abuse (Ray, 2004).

## **16. Substance abuse and family therapy**

In treatment for substance abuse, the client is the identified patient (IP), the person in the immediate family with the presenting substance abuse problem. Treatment in family therapy aims to address the needs of every family member. Family therapy discusses how family ties are interrelated and how they either benefit or harm the IP and other family members. Intervention in these intricate relational patterns and their alteration in ways that result in beneficial effects for the entire family is the main goal of family therapy treatment. Family therapy is based on a systems approach. As a result, modifications to one aspect of the system can and often do affect modifications to other aspects of the system, which can lead to either issues or solutions (Ray, 2004).

It's critical to comprehend the nuanced part families may have in the recovery from substance misuse. They can support the course of treatment, but they also have to deal with the effects of the IP's compulsive activity (Walters, 2012).

Although each family member has their objectives and problems, they are all concerned about the IP's substance misuse. The effectiveness of treatment can be improved by offering services to the entire family. The family therapist, the drug abuse treatment centre, and the family will all need to make adaptations in order to meet the challenge of cooperating. The systemic interactions of families will need to receive more attention to adapt to this change (Ray, 2004).

It supports the family's overall healing process. The two fields' shared presumptions will need to be reexamined to figure out how to work together. Counsellors for substance abuse frequently emphasise the unique requirements of clients with substance use disorders and encourage them to take care of themselves. This perspective fails to emphasise how these modifications will affect other members of the familial system (Walters, 2012).

When the IP is told to ensure that he takes care of himself, he frequently is ill-equipped to handle the emotions of his family members regarding the adjustments he goes through. However, a lot of family therapists have believed that concurrently improving the family system can help with substance use disorder. This perspective tends to downplay the ongoing, perhaps overwhelming nature of the addiction process (Miller et al., 2014).

People who struggle with substance misuse also live in a strong environment that involves the family system. Therefore, both family functioning and individual functioning play key roles in the change process in an integrated substance misuse treatment approach based on family therapy (Liddle and Hogue 2001).

Geographically distant relatives should be included in the therapy process notwithstanding their potential importance in the treatment of substance dependence. While for some clients these boundaries may be hazy, families need to differentiate from social support organisations such as 12-step programmes.

According to a person's closest emotional ties, the family can be determined practically. Clients identify the members of the family they believe should participate in therapy. The counsellor or therapist should ask the patient before starting therapy,

“Who is important to you? What do you consider your family to be?” The importance of persons in a person’s life must be determined. Anyone who contributes to the upkeep of the home provides financial assistance, and has a close and enduring emotional connection with the patient may be regarded as family for therapeutic purposes. The concept of the family can occasionally alter as treatment goes forward, and it can shift again during follow-up care. Other times, clients cannot communicate with the family, may only want certain family members to be seen by the counsellor or therapist, or may want to leave out certain members of their family (Miller & Rollnick, 2013).

### **17. Recovery**

Treatment is crucial to rehabilitation, but it goes far beyond achieving sobriety. “Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.” Treatment does not equal recovery. Adopting lifestyle changes to help heal and reclaim control of one’s life is the process of recovery. Recovery entails taking accountability for one’s actions as well as taking responsibility for them (Miller & Rollnick, 2013).

It is a manner of creating and re-creating healthy living habits. Because rehabilitation is seen as a continuing process, people often refer to themselves as being “in recovery” rather than having “recovered.” To make better decisions and lower their risk of relapsing, people in recovery keep a close eye on their emotions, bodily changes, and interpersonal interactions. Hence the Alcoholics Anonymous saying, “Recovery happens one day at a time ... for the rest of your life”

The different stages of recovery are transition, stabilization, early recovery, middle recovery stage, late recovery stage and maintenance stage. Relapse, nonetheless, does not imply that therapy has failed; rather, it means that treatment has to be resumed, altered, or replaced with another form of care to help the person regain control and heal (Miller & Rollnick, 2013).

Drug addiction recovery can be a protracted process that typically necessitates numerous rounds of therapy. Relapses frequently happen during or following productive therapy periods. Plans for preventing relapse, self-help groups, and other forms of assistance can reduce relapse and encourage abstinence .

## **2.2 Substance Abuse, Its Implications and Solutions**

### **1. Substance Abuse**

Substance abuse is a chronic debilitating disease with significant morbidity and mortality which affects the abuser as well as their families. According to the World Drug Report (2012), around 250 million people between the ages of 15 and 64 took illicit drugs in 2014. Drug or substance-related problems including drug dependency affect 10% of illicit drug users. The majority of drug addicts who use intravenous substances have Hepatitis, and more than 10% of them get HIV (United Nations Office of Substances and Crimes, 2018).

Anything that tends to lead to addiction, habituation, or altered awareness is considered a substance or drug. It can also be described as any chemical that can alter the way the body works or looks. Drugs are taken on a doctor's prescription for medical or nutritional purposes, but when used for other purposes, they can be dangerous.

The DSM-IV defines substance abuse as the repeated use of a drug that has the potential to harm oneself or others physically or socially but is not accompanied by signs or symptoms after the usage is stopped. The United Nations Office on Drugs and Crimes (2015) defines substance addiction (or dependence) as a compulsive pattern of substance use marked by a loss of control over the use of the substance, continued use despite the serious substance-related problems, and the development of an overwhelming sense of physiological symptoms and signs, referred to as withdrawal symptoms, happen when access to the drug is denied. Three characteristics are typically linked to addiction: an inability to stop, the propensity to increase dosage or behaviour, and withdrawal symptoms, which appear after ceasing to use the drug.

Drug addiction progresses via four stages: 1) Experimentation: voluntarily using the substance without changing behaviour; 2) Regular use of the substance: seeking the euphoric benefits of the substance, finding a trustworthy supplier for the substance, etc. 3) Abuse: Consumes drugs regularly. Here, early signs of addiction such as craving, drug obsession, depressive symptoms, etc., start to manifest; 4) Addiction: Physical and/or psychological dependence characterised by uncontrollable drug use despite serious drawbacks and the onset of withdrawal symptoms .

Genetic predisposition, psychological factors like stress, personality characteristics like impulsiveness, anxiety, depression, eating disorders, personality, and other psychiatric disorders, age at first exposure, and self-medications were all implicated in a patient's substance addiction, impairment and environmental factors such as drug availability, social status, peer pressure, drug awareness, sexual abuse or addiction in the family (Kreek et al., 2005; O'Brien et al., 1998). However, it has been demonstrated that several elements, including self-control, academic aptitude, anti-drug knowledge, strong neighbourhood ties, genetics, parents, and an enriching environment, have protective benefits against drug misuse (Botvin et al., 2010). This review highlights potential remedies and seeks to provide a summary of the consequences of substance misuse in various areas. It explains how substance misuse is connected to a variety of social, physical, medical, and psychiatric/psychological problems.

## **2. Implications of Substance Abuse**

The effects of substance misuse on a person's life are profound and can be divided into social, physical, medical, and psychiatric/psychological effects.



## **1) Social implications**

According to Baker, George, and Sandle (1996), substance misuse has numerous societal repercussions, including job loss, interpersonal relationship breakdown, truancy and dropping out of school, suicidal ideation, traffic accidents, and unprotected sex. According to numerous types of studies, there is a strong correlation between substance misuse and unemployment, which can create substantial mental health issues in addicts and was previously believed to be the result of behavioural changes brought on by pre-existing psychopathology such as child abuse, child neglect, and child abandonment with considerable and severe impairments of parent-child interaction have been linked to family disruption and decreased or absent parenting capacity in adults with substance abuse (Bornstein, n.d.). Many different types of literature have demonstrated a substantial relationship between the use of illegal drugs and an elevated crime rate among abusers, which is especially pronounced in alcohol addicts. This was said to be associated with the financial struggles of the substance abusers and the inflated black market costs of the drugs, which were said to be the causes of the impaired cognitive functions of the drug users which encourage illicit conduct and increase an individual's aggressive behaviour (Pernanen, 2001). Usually, the type of substance dictates the form and structure of the crimes. For instance, stimulants, specifically amphetamines, were linked to general crimes, whereas opiates, mostly heroin, were linked to theft and fraud, cannabis, on the other hand, has a tenuous connection to crimes (Fridell, Hesse, Meier & Kühnhorn, 2008).

Another element of the social effects of substance abuse is truancy, where a reciprocal relationship has been shown. In other words, absenteeism raises the likelihood of substance misuse, while substance abuse also raises the rate of absenteeism (Chou, Ho, Chen & Chen, 2006). Additionally, numerous studies have demonstrated the link between the use of illegal substances and school dropout, with a significant dropout rate observed in drug users. Numerous epidemiological studies have linked driving under the influence of drugs to an increased risk of traffic accidents, which were believed to be caused by the addicts' impaired cognitive and

psychomotor abilities. In this respect, benzodiazepines were found to carry the highest risk. There is a statistically substantial link between using illegal substances and making suicide attempts or engaging in other self-destructive activities, which is particularly prevalent in young adults who lack formal education and are unemployed (Mohammed, 2012). Additionally, a strong link was identified between drug consumption and unprotected and unscheduled sexual activity, particularly among higher college students (Hingson et al., 2003). For instance, drinking is significantly associated with the chance of engaging in risky sexual conduct with several partners, which increases the risk of developing serious sexually transmitted illnesses.

## **2) Physical implications**

Every year, over one million children in America are subjected to physical or sexual abuse, primarily as a result of parental alcoholism. All types of maltreatment that could leave a victim with physical wounds including bruising, lacerations, fractures, or burns are referred to as physical abuse. Physical abuse can include neglect, which includes failing to give children food, shelter, clothing, or medical attention. Additionally, acts of physical abuses that are sexual, such as rape, touching, kissing, or even stroking, may qualify. It has been demonstrated that substance misuse is associated with self-inflicted bodily wounds including cuts, bruises, or even burns. In the study by Blose et al., hospital admissions for injuries-related reasons are much greater among addicts than they are among non-addicts. This suggests that the injury rate is higher in addicts than in non-addicts. There is a substantial amount of research linking substance usage to physical signs like agitation, tremors, confusion, and restlessness, which are considered to be parts of withdrawal symptoms brought on by central nervous system activation (Hodding, Angeles, Jann, Ackerman & Angeles, 1980).

## **3) Medical implications**

Between 1980 and 1986, 269 hospitalised patients in Switzerland were discovered to have histories of drug misuse. Infectious problems affect over 47% of

patients, with lung infections being the most often found infections, partly as a result of the high heroin usage rate (approximately 95% of patients). 16.4% of the patients had viral hepatitis, 11.1% had HIV infection, 9.3% have minor vaginal infections, and 2.6% have sepsis, endocarditis, and bone and joint infections, respectively. A 25-year-old intravenous drug user had a lengthy and sustained bacteraemia that persisted despite numerous antibiotic regimens, according to a case study by Goel et al., (2016). This confirms the possibility of bacteraemia in injecting drug addicts. Inhalants like glue are closely linked to the danger of lung, brain, and liver damage, as well as anaemia and death through asphyxia or choking.

While heroin usage increases the likelihood of brain and liver damage, drugs can also cause hepatitis and embolism. Intravenous medications linked to systemic illnesses like endocarditis can cause stroke or cerebral embolism, which can have an impact on the brain. Hepatic or HIV-induced encephalopathy can result from viral hepatitis or HIV infections, which are frequently treated. Chronic drug users may develop right-sided infective endocarditis; extremely occasionally, they may also exhibit pulmonary hypertension or oedema, particularly in those who abuse heroin, cocaine, and amphetamines. They may also very frequently exhibit tuberculosis, bacterial pneumonia, aspiration pneumonia, and pulmonary infections. As previously stated, intravenous drug addicts are at the highest risk of contracting Hepatitis B, C, and D, with drug users accounting for around 20% of illnesses in America, for instance. Cocaine addiction was linked to both acute and long-term kidney damage, interstitial nephritis, and glomerulonephritis (Committee & Editors, Eastern Journal of Psychiatry, 2009).

#### **4) Psychiatric/psychological implications**

Numerous clinical and epidemiological investigations have shown the connection between alcoholism and chronic anxiety disorder, which is more common in males than in women. According to a research study by Kushner et al., between 20 and 45 percent of those with anxiety disorders have a history of drinking, and between 23 and 70 percent of drinkers have anxiety disorders, notably phobias and neurosis. In numerous family investigations, it was also discovered that relatives of

individuals with alcoholism had a greater prevalence of anxiety disorders. These results suggest that drunkenness has a role in the emergence of anxiety disorders. In two American communities, Sareen et al., found a link between chronic use of amphetamines, cocaine, hallucinogens, and heroin and anxiety disorders like social phobia, panic disorder, agoraphobia, specific phobia, and generalised anxiety disorder. Numerous studies have linked maternal drug use during pregnancy to significant declines in cerebral reserve capacity and functions, smaller newborn brains with less capacity to make up for adult-onset cognitive decline that may lead to neurodegenerative diseases like Alzheimer's disease and presenile dementia, and decreased cerebral size (Fein & Sclafani, 2004).

Particularly in people who misuse alcohol, benzodiazepines, cigarettes, and cannabis regularly, there is a strong correlation between chronic substance abuse and the risk of cognitive deficits and dementia. However, the function of alcohol solely in alcohol-induced dementia is hotly contested and was once thought to be a contributing component regardless of other factors. Heavy and frequent alcohol use is strongly connected with a greater likelihood of dementia. Although some case-control research has claimed that smoking is beneficial in the treatment of dementia because nicotine, which dependency is a cholinergic agent, is the primary objective of dementia treatment, recent data from cohort studies conflict with these assertions because these studies have linked smoking to Alzheimer's dementia. The European Community Concerted Action Epidemiology of Dementia (EURODEM) study currently supports this adverse association. Additionally, recent research revealed a link between benzodiazepines and cognitive decline, with those who have ever used them having a 1.7-fold increased risk of developing dementia compared to those who have never used them. Clinical research on major depressive disorder (MDD) and other mental illnesses has long shown a high correlation between substance addiction disorder and depression.

In numerous researches, maternal substance usage was also linked to the emergence of severe depressive disorder. The treatment of both mental and drug addiction disorders is significantly hampered by the frequent associations between

psychiatric diseases and substance abuse. Therefore, all individuals with psychiatric illnesses should be treated with a high degree of concern for the likelihood of drug misuse. Patients with previous records of substance abuse frequently have psychosis, especially chronic drinkers. They frequently exhibit ominous suspicions, paranoid thoughts, delusions, or hallucinations, and are more prevalent in women and those under 30 years old (Hoffbrand & Brown, 1988).

### **3. Solutions to Substance Abuse**

The greatest way to combat drug addiction is through prevention, and these preventive methods are beneficial in doing so. These include public education initiatives to raise society's overall understanding of the issues; seminars, workshops, and the media can all be used to this end. Another efficient technique for prevention is preventive education, especially when it is provided to specific target populations like families, schools, workplaces, religious institutions, and unschooled young. The provision of recreational facilities for youth in rural and urban areas, moral rearmament that de-emphasizes materialism, increased possibilities for employment, and effective control of drug availability, as well as drug education as part of the school curriculum, is additional preventive measures (Johnson et al., 1990). A psychological restructuring of society as a whole and policymakers is necessary for an efficient avoidance of drug misuse, in which denial of the threat should end and the true nature of the problem should be made clear to the rich, educated, employed, jobless, or even community leaders. Children are most at risk of developing a drug addiction in homes where both parents use drugs, partly because of the stress and suffering that they may experience as a result of neglect and bad parenting.

An early pregnancy and infancy visitation programme should be established, in which a certified nurse or social worker visits expectant mothers and mothers of these children to offer encouragement for dealing with problems that might assist mothers to stop abusing drugs and the skills that could improve parent-child interaction, to avert substance abuse in these groups of children. The most effective method of preventing substance misuse in young children is to provide them with early education programmes delivered by qualified instructors and to address their

socioeconomic issues. Parenting skills programmes are the most efficient method to stop adolescents from abusing drugs during the middle adolescent years. Parents are instructed in warm child-rearing techniques, given advice on how to set boundaries for appropriate behaviour, educated on how to closely watch their kids during free time, and taught how to make friends and develop personal and social skills. They should be taught how to avoid peer pressure towards illicit substance use by developing negative attitudes towards substance usage because social influence tends to be an important predictor of teenage drug abuse. A programme called behavioural pair therapy, which entails bringing the substance abuser and spouse or live-in companion together to encourage sobriety and strengthen the relationship, could be quite helpful for people who are already addicted. The couples are encouraged to create daily plans of activities which could reinforce abstinence in order to do this

Contingency management therapies, which reward certain actions, are among the other behavioural treatments for drug addicts. The person is given tasks to complete and is then rewarded after achieving the objectives. Cognitive Behaviour and Skills Training Therapies are a type of behavioural therapy where a person learns to recognise the situations where drug use is most likely to occur and how to avoid such situations by developing coping mechanisms. Adolescents enrolled in school can receive preventive measures through educational programmes that teach them how to build self-worth, deal with anxiety, resist peer pressure, and communicate effectively through group discussions, presentations, seminars, rehearsals, and behavioural assignments (Botvin, Griffin, Diaz & Ifill-Williams, 2010). Numerous studies have demonstrated the great effectiveness of family-based therapy in the management of substance misuse, particularly in teenagers. It is a crucial element in motivating the addict to adhere to rehabilitation and clinical follow-up, dramatically lowering the likelihood of drug use, eliminating negative behaviours, and especially increasing personal and social skills. Educating students about the dangers of drug misuse, providing health education and drug abuse prevention programmes, and implementing school policies like drug-free schools are all vital ways to reduce drug abuse in schools (Botvin et al., 2010).

Improving beneficial health behaviours and discouraging harmful health behaviours by addressing personality, behaviours, and surroundings via community organisations, educational interventions, and health behaviour campaigns are two main strategies used in health promotion programmes that are effective in preventing drug abuse. In a study by Pentz et al., extensive community programs, such as mass media campaigns, school-based educational programs, parent education regarding the involvement of children's homework, community organisations and presentations, as well as health policies that seriously deal with drug addictions, especially in schools, have had a major impact on the reductions of drug abuse rates among adolescents. Pharmacotherapy, outpatient counseling-based care, and therapeutic communities are three clinical treatment modalities that can be used on the patient. Levo-alpha acetylmethadol (LAAM), a methadone derivative, and Naltrexone, a fast-acting opiate antagonist, are all used in pharmacotherapy to treat heroin and other opiate addiction. The most popular technique for treating drug abusers is through a counselling programme, which involves psychotherapy, peer counselling, and several meetings. A programme that prioritises socialisation, lifestyle changes, and behavioural improvement is called a therapeutic community.

Drug and alcohol abuse is a widespread issue that mostly affects children and young people and leads to severe physical, social, and health-related issues. Although there are many different types of misused drugs, cannabis is still the most popular one. Substance misuse is a growing threat, especially among adolescents, due to social and economic issues with the readily available narcotics. The main effects of substance misuse have been highlighted in this overview, along with a thorough explanation of the issues they cause. The main preventive tactics have also been thoroughly discussed and clarified. Drug misuse issues are typically addressed through a variety of tactics, including public awareness campaigns, educational initiatives, and school- and community-based programmes. However, addiction may be dealt with by realising that addiction is a critical public issue that disproportionately affects the poor. In cases when a person is physiologically dependent on a drug, patient treatment may be necessary.

### 2.3. Family and Substance Abuse

Definitions are influenced by many cultures and belief systems, and since cultures and beliefs evolve through time, definitions of the family are by no means constant. While there are many different ways to define a family, most fall into one of several broad categories, these include: i) traditional families, which include heterosexual couples with minor children who live together, single parents, and families made up of blood relatives, adoptive families, foster families, grandparents raising grandchildren, and step-families; ii) Extended Families which is made up of grandparents, uncles, aunts, cousins, and other relatives and iii) Elected families, which identify themselves and join together voluntarily rather than through the customary connections of blood, marriage, and the law. Many people place greater value on their adopted family than their original family.

Family, according to Duvall (1977), is a “*group of people with common ties of affection and responsibility who live in proximity to one another*”. They broaden that concept, though, by pointing out four aspects of families fundamental to family therapy:

- 1) Families are non-summative, which indicates that they are larger than the sum of their parts and distinct from it.
- 2) Circular causality, which postulates that if one family member modifies their behaviour, the others will follow suit and change as a result, which in turn prompts further modifications in the original member, explains how the behaviour of individual family members is interrelated. This shows that it is impossible to predict which behaviour—drug usage or “enabling” behaviours—occurs first.
- 3) Each family has a set of communication features that they use to express emotion, conflict, affection, etc. These traits can be verbal or nonverbal, overt or covert.

Families work to maintain homeostasis, which depicts family structures as self-regulating with a focus on preserving equilibrium.



## 1. Family Systems

Family systems can be open or closed. Open family systems allow members to share information, have discussions, and give and receive feedback while maintaining flexible boundaries. Closed family systems limit environmental influences to safeguard the family and uphold the status quo by having strict boundaries and a commanding communication style (Duvall, 1977).

Closed family structures, according to L'Abate, Ganahl and Hansen (1986), often exhibit two fundamental issues: "*detachment*," or exaggerated separateness, and "*enmeshment*," or exaggerated closeness. Members of a closed family structure that is disconnected work independently and with a high degree of self-sufficiency, with little familial interdependence. However, family members frequently fail to meet each other's social and emotional needs and interact seldom or not at all. They are like passing ships in the night. Additionally, support is rarely provided until a person is experiencing a significant problem or crisis because boundaries in closed, disconnected families are so rigid.

Too much "*O togetherness*" throws a closed family system with the enmeshment issue out of balance. In such families, interpersonal interactions are frequently emotionally charged and the members are too invested in and concerned about one another's lives. Closed/enmeshed families have very weak, easily traversed, and weakly distinct boundaries. Instead of encouraging effective problem-solving, this family system frequently hurries to save a member from a difficult circumstance. Generally speaking, open-family systems that support and promote adaptation, individuality, affection, collaboration, flexibility, and togetherness are where normative growth, development, and equilibrium occurs the most.

The functional family is often modelled after the open family in popular culture. In these settings, children are least likely to suffer emotional harm and have the highest chance of leading healthy lives as adults. The highest risk of emotional harm and poorer adult health is, however, present in children from closed family systems. Because they have missed out on healthy interactions inside their families

of origin, children and teens from separated homes frequently create poor or unhealthy relationships outside the family. People from separated family structures are more prone to drop out of school, flee, possibly wind up on the streets, and develop independent attitudes. Children and teens in entangled households are constrained by the overprotectiveness of the family, predisposed to becoming too dependent and more likely to manipulate others to get what they want. Such people frequently engage in denial, rationalisation, externalisation, and passive aggression (L'Abate, Ganahl & Hansen, 1986).

## **2. Family Life Cycle**

According to Duvall (1977), Thomas (1992), L'Abate, Ganahl, and Hansen (1986), certain phases or transitions call for alterations in attitudes and behaviours but also put a strain on families and upset their equilibrium. Carter and McGoldrick (1988) emphasise the dynamic nature of every family system, where emotional transitions and responsibilities change through six stages: (1) single adults leave home; (2) couples marry; (3) families with young children; (4) families with adolescents; (5) launching young adults and moving on; and (6) families in later life, recognising the various changes that families' experience and making plans to address the particular issues faced by parents and kids at each stage of family life are just common sense.

When a person's use of alcohol or other mood-altering substances interferes with or has unfavourable impacts on their life and the lives of others, it is considered to be a dysfunctional condition (Black, 1981; Lewis, 1992). Abuse of drugs or alcohol by family members has a significant impact on family systems, which frequently jeopardizes the health and functioning of families. From substance abstinence to substance usage to substance abuse to substance addiction, there is a continuum of substance misuse. While substance addiction normally involves both physical and psychological dependence, substance abuse frequently only involves psychological dependence (Lewis, 1992).

### **3. Influence of Substance Abuse on Families**

Since the family is a dynamic structure, it develops and changes as its members do. As a result, the behaviour of substance use by one of its members—whether it be occasional use or addiction—will have an impact on the entire system, and if we want the behaviour to stop or lessen, we must strive to act on the said system.

Substance addiction harms both physical and mental health, as well as the organisations that support these two areas of well-being. Family members in drug-abusing households frequently have connections with many governmental organisations, including social services, criminal justice, and child protective services, in addition to one another. Families strive to maintain harmony and return to homeostasis. When abstinence is attained, this might become most obvious. For instance, when a substance abuser stops using, other people may start to experience complaints or other “*symptoms.*” The desire of family members to improve the family system as a whole may be stronger, motivating and perhaps giving the substance abuser leverage to seek and/or stay in treatment even during times when they are undecided about pursuing a clean lifestyle. Alternately, defining boundaries between dysfunctional family members, such as urging substance users to distance themselves from family members who are currently abusing substances can reduce stress and free up emotional space for the user to concentrate on the chores of recovery (L’Abate, Ganahl & Hansen, 1986).

Avoiding disagreement with a drug user has been shown to enhance substance abuse behaviours (McCrary & Epstein, 1995) Family members’ disapproval and distance may prevent the abuser from facing addiction and related actions (McCrary & Epstein, 1995). Because it “enables” the abuser to be more mentally available to other family members, alcohol abuse is frequently condoned.

In the substance-affected family, functional family roles are often distorted or missing (Haber, 2000). It is possible to think of a family as a system with interdependencies among its members. According to this viewpoint, when one

component of the system is altered or “*damaged*,” it affects the remaining components. Another aspect is that the family may change as a unit to protect and support the substance user, which could result in accommodating problematic family dynamics. The establishment of family regulations and practises that cover up family member-dependent behaviour are also common components of this adaptation (Stevens-Smith, 1998). The possibility of a reciprocal impact between substance use and abuse and other family member conduct is another implication of a systemic perspective.

According to Stewart and Brown (1993), the beginning of substance misuse is typically accompanied by stress and may be brought on by problems with the family, problems with control or management, or losses (Bennett, 1995).

As a result, it is widely known that families frequently play a crucial part in the course of alcohol or drug addiction and its treatment (Liddle & Dakof, 1995; Margolis & Zweben, 1998; Moos, Finney, & Cronkite, 1990; O’Farrell & Fraser, 2006) (Edwards & Steinglass, 1995; cf. O’Farrell; 1993).

Even though substance abuse impacts entire families, children whose parents misuse drugs or alcohol have only recently come to the forefront of discussion. More lately, the emphasis has switched to the specific repercussions for children as a result of a rising realisation that drug usage has an impact on the entire family (Zulligt, 2012). In addition to prenatal drug exposure, children may also be at high risk from variables unrelated to drug use, like inconsistent care and physical abuse (Schafer and Brown, 1991).

Families are significant stakeholders who both support the course of change and gain from the reduction of an addiction problem, according to Copello and Orford (2002), who made this argument based on a review of the research. They concluded that there are significant advantages to recognising and utilising families’ contributions to getting substance abusers into treatment, sustaining their engagement, and improving.

The entire family system, not just the substance abuser, needs to change, whether the family member is a youngster or an adult. Therefore, family therapy assists the family in implementing interpersonal, intrapersonal, and environmental adjustments that have an impact on the alcohol or drug user (Copello and Orford, 2002).

Numerous studies have shown that if one family member consumes alcohol or drugs, the other family members are more likely to experience difficulties with substance misuse. Parental substance abuse is the single most significant risk factor for future maladaptation, propensity to use drugs, and psychological issues (Johnson and Leff 1999).

Even in the face of strong peer pressure to use and misuse drugs, a “*healthy family structure can prevent adolescent substance abuse*” (Kaufman 1985). Additionally, when a teenager is taking substances, effective treatment reduces the possibility that siblings will do the same or commit crimes connected to substance misuse (Arria et al., 2008).

#### **4. Family Effect**

The quality of family life is strongly and mostly negatively correlated with substance misuse, especially long-term and progressive abuse. More than 10% of American children are or have grown up in alcoholic households, according to Ackerman’s data from 1983; however, the National Association of Children of Alcoholics (NACOA) found that this number was 18% in 1999. The number of children of alcoholics in our society that fall into this category ranges from 30 million (Ackerman, 1981) to 76 million (National Association for Children of Alcoholics, 1999).

According to Black (1981), 50% of the offspring of alcoholics will develop alcoholism themselves. Almost all facets of family life are typically negatively impacted by substance misuse, particularly in the psychological and social spheres. Negative emotions (such as stress, rage, and despair), inconsistency, abuse, abandonment, and deception all contribute to less stable families. Chronic liars result

from substance abuse, and family members who are codependent and enablers frequently tell lies as well. Once people stop using alcohol and drugs moderately and start becoming psychologically and physically dependent, or both, their state and the family system change.

If use develops into abuse and addiction, problem substance use typically traumatises the family system (Hawkins, 1998), and this prompts codependent family members and substance abusers to go through a process of short and long-term adjustment as a coping mechanism. According to Cecil (1985), denial is the main defence against any type of surrender to recovery. People employ denial as a form of self-delusion to cope with suffering and loss. Denial is a transient state that can last for years or until people feel secure enough to find other methods to cope (Beattie, 1987).

Particularly stressful and traumatic experiences, such as divorce, poor grades, and DUI arrests, can cause people to go into denial, blocking out their understanding of and acceptance of reality (Jewett, 1982). Ackerman (1987), who co-founded the National Association for Children of Alcoholics, recognised four phases in the family's reactions to a parent who abuses drugs or alcohol – reactive, active, alternative, and unity are these phases.

Denial, verbal coping (e.g., “nagging”), behavioural coping (e.g., hiding alcohol), and social, physical, and emotional disengagement/isolation are just a few of the methods used by families in the reactive phase to cope with a stressful situation. The reactive phase, which frequently incorporates “toxic shame” (Bradshaw, 1988; Hawkins, 1998) and is characterised by families keeping secrets regarding emotional, physical, and sexual abuse, is one that many families never leave.

To move on to the later, more functional stages of coping, professional assistance is frequently required. A good 10-concept acronym for a healthy family that can direct intervention efforts is “Functional” (Hawkins, 1998). The acronym FUNCTIONAL stands for: Freedom of perception, thought, emotion, choice, and

creativity; Unfolding intimacy; Negotiating differences; Trusting; Individuality; Open and Flexible Roles; Needs met for All Family Members; Accountability; and Open and Flexible Laws. Ackerman suggests that non-abusive members of the family start to become more conscious of their wants and needs, lessen denial, and continue some normal activities in the second, or “active,” phase. Families in this active stage show increasing self-efficacy and are rising from the abuser’s all-consuming shadow.

### **i) Child Impact**

Children of alcoholic (or drug-using) parents are more likely to be neglected and abused than ‘normal’ children, and they are also more likely to develop a substance use disorder or to associate with and marry other substance users. A high risk of emotional and social adjustment issues, including aggression, hyperactivity, relationship problems, depression, underachievement or low grades, school absenteeism, and school dropout, is also present in children from such homes (West & Prinz, 1987). Neglect and abuse are also frequently associated with social immaturity, low self-esteem, low self-efficacy, and social skill deficiencies. Generally speaking, if it lasts a longer period and involves several traumas (such as neglect, various forms of abuse, and divorce), the detrimental impact will be larger.

Pia Mellody (Mellody, Miller & Miller, 1989), who identifies as a codependent and a child of abuse, thinks that the worst side effect of drug usage is emotional harm. In dysfunctional families, emotions like anger, fear, sorrow, guilt, and shame are presented in an unhealthy and harmful way. The dysfunctional family appears to manufacture disempowerment by overreacting negatively, but strong emotions in functioning families can be empowering, such as employing fear to protect ourselves or shame to urge behaviour change. Children’s innate tendencies to be valuable, fragile, imperfect, reliant, immature, extremely active, and flexible are impeded in homes with dysfunction brought on by substance misuse. Furthermore, parents who are overprotective or controlling attack or dismiss their children frequently and undermine their efforts at effective mentorship. According to Mellody et al.’s (1989) research in a treatment facility, when children’s natural features are

misused, they develop dysfunctional survival skills that turn into fundamental signs of co-dependency that may develop into a chronic illness in adulthood. Table 1 lists the key survival skills that frequently develop into co-dependency signs as children grow into adults. People are motivated or triggered to take on duties that will aid their families and themselves to survive stress, instability, and dissatisfaction (Hawkins, 1998).

Although sometimes ambiguous, these roles—family hero, lost kid, scapegoat, or mascot—frequently influence how families interact. The “*Family Hero*” is a high achiever who is four perfectionists, acts morally, and prioritises others. The “*Lost Child*” is reclusive, devoid of joy, and essentially unnoticeable. The “*Scapegoat*,” who is frequently a drug user, presents as belligerent and defiant but feels emotionally hurt and enraged. Children who play the part of the victim seek attention by negative behaviour, and they are more likely to grow up to consume drugs. The “*Mascot*,” a delightful and lovable family clown, comes in last.

People who lack self-efficacy and dedication frequently adopt this character (Wegschieder-Cruse, 1981). Families with chemical dependencies has reportedly spent at least some of their lives in a confused and unstable environment, leading to role distortion, imbalance, and inadequate emotional support. I think there is much benefit in studying the major functions that are assumed by traumatised family systems. Making positive adjustments as a family and as individuals can start with such understanding. When all else seems to have failed, a family may enter the third, or “alternative,” phase of their response to a parent who abuses drugs or alcohol. Polarisation, segregation, contentment with change, and family restructuring are characteristics of this. The safety of many children is challenged by the combined peril of being the children of alcoholics and children of divorce because alcoholism accounts for 40% of family court proceedings (Ackerman, 1981).

Families that progress to the fourth phase, known as “family unity,” are among the most functional and exhibit development and substance abstinence. These families desire consistency, harmony, growth, and quality, particularly when it comes to their interpersonal interactions.



## **ii) Effects on Adult Children**

The consequences of parental substance usage are frequently traumatising and can last far into adulthood, and in some cases, for the rest of a person's life. In this regard, post-traumatic stress disorder affects a large number of adult children of alcoholics and other substance abusers. Adult children of substance abusers frequently experience hyper-maturity and indecisiveness, as well as a lack of trust, loneliness, emotional denial, feelings of guilt, shame, rage, sadness, an uncertain sense of self, a need for control, a lack of assertiveness, a desperate desire to please others, and an exaggerated response to personal criticism (Black, 1981; Seixas & Youcha, 1985).

Similar to this, Wilsnack (1996) mentions 13 traits or symptoms in Adult Children of Alcoholics that might cause lifelong issues and that seem to be 20% more common in adult children of alcoholics (Hager et al., 1988). Wilsnack (1996) generalises that the majority of adult children of alcoholics misjudge what constitutes a typical struggle to complete projects, lie when it would be just as easy, to tell the truth, constantly look for approval and validation feel that they are different, are highly responsible or irresponsible, assess themselves very harshly, have difficulty with close relationships, overreact to changes beyond their control, are extremely loyal, and act without thinking about the repercussions. Adult children of substance abusers who are frequently too dependent, anti-dependent, unnecessary, and wanting less seem to have difficulty sustaining balance and being moderate. It should come as no surprise that people like this frequently struggle to identify and meet their wants and needs as adults. According to Mellody, Miller, and Miller (1989), "too dependent adults" spend a lot of time complaining and manipulating others to satisfy their needs or wants, but they are reluctant or unwilling to ask due to childhood memories of abuse they had if they did ask and did not get what they wanted.

Adults who are "needless and want less" are unaware that they might have wants and needs, and they may even question whether these things are fundamental human rights. It's also common for adult offspring of substance abusers to originate from closed family structures with the issue of "enmeshment." However, most are

anti-dependent, unnecessary, and want fewer adult offspring of drug addicts to come from closed households with the issue of separation (Mellody et al., 1989).

### **iii) Cultural Influences on Families and Substance Abuse**

One of the many cultural factors that have an impact on families and individuals is substance misuse. Macro systems like a person's extended family, national society, the government, and ethnicity and race are influences. Other little elements affect families and misuse of drugs, such as gender, heredity, and social support. According to research by Cork (1969), children who have an alcoholic mother exhibit greater behavioural and emotional issues. Another systemic effect is the study of biological or genetic determinism. Even though studies show that children of substance abusers have a higher chance of becoming substance abusers as adults, they also come far short of being able to predict a child's future adjustment based just on parental substance usage (Hager et al., 1988).

A transactional model of human development is supported by inconsistent or unconvincing results, which highlight the resilience of offspring (Werner, 1985). Social support is increasingly understood to play a significant role in reducing the detrimental impacts of chemical dependency on families and people. For instance, a study by Ackerman (1987) showed that children of alcoholics who had close surrogate relationships beyond the house were far less likely to develop into alcoholics themselves as adults. Peer support groups have helped millions of drug users and their loved ones mature, gain control, and achieve balance as part of a seemingly ever-expanding national movement. The scope of this chapter does not allow for a thorough discussion of cultural impacts on families and substance abuse.

However, since cultural effects are ever-present, it is advantageous for us to tailor planning and intervention such that it takes culture into account. The diversity of cultures and its implications for service planning and delivery have recently risen to the top of the research agenda in social sciences and education, with the potential to significantly improve efforts at social problem prevention and intervention (Freeman, 1993). Assessing people in regards to whether their familial background

largely reflects the concept of either collectivism or individualism is a prime instance of promising cultural elements study.

### **5. Family Approaches to Substance Abuse Treatment**

Brown and Lewis (1999) established that “family-focused interventions are empirically well-supported for youth with a conduct disorder or substance use disorder.” He points out that 68% of young people with substance use disorders also have disruptive behaviour disorders. It is important to note that Bukstein says family therapy approaches might concentrate on the environmental triggers for both diseases.

Cattarello et al., (1995) investigated whether family-centred therapies for methadone-using parents would lessen their drug use and keep kids from becoming drug users. The authors discovered appreciable gains in parenting abilities, a decrease in parental drug use, a decrease in deviant peers, and stronger family management after observing 144 methadone-treated parents with 78 kids for a year and 33 sessions of family training.

In their review of multi-systemic therapy, a family-based treatment model, Brown and Lewis (1999), observed high completion rates of substance addiction treatment among young people with significant clinical issues.

Research developments in family-based treatment were evaluated by Waldron in 1997. They noted an expanding body of evidence showing that family-based therapies are successful in treating a range of diseases affecting children and adolescents, such as substance misuse, schizophrenia, and behavioural disorders. The studies all showed that brief family therapy was more effective than solo and group therapy at lowering drug use.

In six outpatient drug-free programmes involving family therapy sessions, 176 teenage drug misuse clients and their mothers participated in a study by Cattarello et al., (1995). The authors discovered that the client’s progress was found by the client or mother at the follow-up to be greater the more favourably the client

described the family's functioning and connections during pre-treatment. They concluded that the teenagers who saw better treatment outcomes started with more favourable views of their families.

Liddle and Dakof (1995) examined controlled treatment outcome research and discovered that various family intervention strategies can engage and keep drug users and their families in treatment, dramatically lower drug use and other problematic behaviours, and improve social functioning. In addition, they concluded that family treatment was superior to therapy without families, although they issued a warning against oversimplifying this conclusion due to methodological constraints and the very limited number of trials.

The efficacy of treatment based on familial disease, systems of families, and behavioural family models is supported by a large body of evidence, according to McCrady and Epstein (1995). The absence of studies on couple's treatment for drug users, family treatment for people with alcohol consumption disorders, and cultural, racial, sexual, and gender orientation concerns among subjects all limit the knowledge that can be gained through studies.

O'Farrell and Fals-Stewart (2000) concluded that behavioural couples therapy had a better cost-benefit ratio than individual treatment, increased abstinence and improved relationships, lowered the frequency of divorce and separation, and decreased domestic violence.

La Bodega de la Familia, according to Seixas (1985), is a family therapy technique intended to help people who have been released from prison or jail prevent recidivism, parole violations, and relapse. The 18-month re-arrest rate decreased from 50% to 35% with intensive family-based interventions.

Schafer and Brown (1991) came to the following conclusions after comparing family-couples therapy and non-family treatments for addiction to substances: (1) family-couples therapy produced better results than non-family treatment modalities, and (2) family therapy encourages client engagement and retention.

For the treatment of substance misuse, Waldron (1997) examined two types of family therapy (behavioural marital therapy and family systems therapy), concluding that the model to adopt depends on the issue at hand. Behavioural marital therapy was the preferable course of action when issues (such as poor communication) were marriage-related. Family systems therapy may be a better course of action if the issue impacted an entire family that was centred on alcohol or other substances.

In either case, her appraisal” strongly indicates the critical role family functioning can have in both subtly maintaining addiction and in creating an environment conducive to abstinence”.

## **2.4. Family Functioning**

### **1. Substance Abuse Occurrence in Families**

#### **i) Incidence and Prevalence**

Alcoholism is most prevalent in the age group of 18-44 when many individuals are getting married and having families. The National Household Survey on Drug Abuse (NHSDA), conducted in 2000 and 2001, found that 20.5% of those 12 and over reported binge drinking (defined as more than 5 drinks on at least one occasion during the past 30 days). An additional 5.7 % (or 12.9 million people) reported heavy drinking (defined as 5 or more drinks on the same occasion more than 5 days in the past 30 days). An estimated 7.1% of the population or 15.9 million people over the age of 12 reported the use of an illicit drug within a month of the interview (SAMHSA, 2001). Half of the women who report using drugs are in the childbearing age group of 15-44 (National Institute of Drug Abuse [NIDA], 1997). In two national surveys (SAMHSA, 2001), 3.7% of pregnant women reported using illicit drugs in the past month, while 12.9% of pregnant women reported using alcohol and 4.6% reported bingeing. These rates are much lower compared to those for non-pregnant women (49.8% alcohol use, 20.5% binge drinking) (SAMHSA, 2001).

SAMHSA's Office of Applied Studies, Substance Abuse and Mental Health Statistics Sourcebook (Rouse, 1998) reports that family structure is related to illicit substance use among adolescents (12 -17). Based on data collected between 1991-1993, adolescents in families with both biological parents present were least likely to report substance use (approximately 11%), whereas youths from stepparent or one-parent households (approximately 18%) were most likely to use illicit drugs.

## **ii) Genetics and Family History as Causal Factors of Substance Abuse**

While substance abuse is a multi-dimensional phenomenon without a clear "cause," the literature suggests that genetically influenced factors have been found to account for 60% of the variance of risk for an alcohol use disorder, with the remaining 40% thought to be sociocultural and environmental (Shuckit & Smith, 2001). Although no substance-dependent gene has been found, there is evidence that a predisposition towards alcoholism may be passed on from father to son (McGue, 1993).

The evidence is less conclusive for a heritable component for alcoholism among women. Other work (e.g., Froehlich & Li, 1993; Gorelick, 1993) suggests a genetic role in determining the brain's response to alcohol dependency and use. While a familial combination of genetic and environmental factors is contributory, a predisposition to developing an abusive consumption habit does not automatically produce alcoholism, problem drinking, or even alcohol use. Family and other social environmental factors can impede any genetic predisposition to use and/or abuse alcohol (Goodwin, 1995; Jang, Vernon, Livesley, Stein & Wolf, 2001).

Studies have found that there are other important factors linking substance abuse directly to the family (Grant, 2000; Juliana & Goodman, 1997; McCrady & Epstein, 1995; Steinglass, Bennett, Wolin & Reiss, 1987). For example, children who grow up with an alcoholic parent are at increased risk of abusing alcohol (Baer, Garmezny, McLaughlin, Pokorny & Wernick, 1987).

Family history is further implicated in McMahon and Luthar's (1998) report of research showing that substance-abusing parents are more likely to have grown up

in chaotic and emotionally problematic family environments: families characterized by psychological maltreatment due to parental neglect, physical or sexual abuse, economic distress, and other family depleting conditions. Moreover, parents from substance-abusing homes are more likely to report the parenting styles of their parents as punitive and authoritarian.

### **iii) Family Environment and Substance Use**

The family environment often plays a significant role in the use of alcohol and other drugs. Unstable and inconsistent family and living environment factors (e.g., transient living conditions, inconsistent caretaking, violence) resulting from substance-using caretakers have been linked to the incidence of psychological and emotional development problems among their children. In families where alcohol and other drugs are used or attitudes towards their use are positive, the incidence of children's usage is higher than in families where usage is low and where attitudes towards drugs are not as permissive (Brook et al., 1990).

Gfroerer (1987) reported that among a sample of adolescents and their older siblings and parents, youths were twice as likely to try marijuana if there was parental or older sibling drug use. Boyd and Holmes (2002) found among a sample of African American women cocaine users that their substance use paralleled the use patterns of their family members, particularly those of fathers, uncles, and brothers. Alcoholism is also less likely to be passed on to offspring among families that maintain family rituals (Wynne et al., 1996), while children from families with one or both alcoholic parents who experience disrupted family rituals surrounding dinner time, evenings, holidays, weekends, vacations, and visitors are more likely themselves to develop alcohol use problems (Wohlin et.al., 1980).

Role expectations and structures within the family may be obstacles to addressing substance misuse and addiction problems. Drug addiction behaviour is correlated with family system processes that deal with emotion regulation, communication between roles, and need satisfaction (Haber, 2000). For instance, it might be difficult for the family to change the alcoholic's drinking status when

alcohol-related behaviours are deeply ingrained in routines, rituals, and problem-solving techniques (Steinglass et al., 1987). Avoiding disagreement with a drug user has been shown to enhance substance abuse behaviours (McCrary & Epstein, 1995; O'Farrell & Fals-Stewart, 2000).

Family members' disapproval and distance may prevent the abuser from facing addiction and related actions (McCrary & Epstein, 1995). Because it "enables" the substance abuser to be emotionally available to other family members, alcohol abuse is frequently condoned. Families "may develop an addiction to crises of emotion because crises are the only way to get in touch with and express generally repressed or suppressed feelings," according to Haber (2000) (p. 316). As it causes family conflict and a bad family atmosphere, disregarding or avoiding alcohol consumption as a problem is frequently linked to severe unhappiness among relatives as well as the immediate family.

Furthermore, various addictive behaviours have been discovered to be more common in some families than others. The family may play several roles in the development, maintenance, and recovery from addictive illnesses, despite the many explanations offered. A variety of factors, including modelling, inadequate parenting, relationship and structural problems, support, the sociocultural context of the family, and socioeconomic level, may be involved in different parts of addictive illnesses. To address the issue of addictive behaviour at different phases and for prevention, it's crucial to have a thorough grasp of these elements. Better results may result from the family's participation and appropriate concern (Orford et al., 2001).

In addition, the family is the fundamental societal unit and the starting point for socialisation. A person's family influences how they consciously and unconsciously learn, perceive, and value many things. The family's values, traditions, and actions leave an impression on the person, as do their behaviours, coping mechanisms, and morality. The family may view substance use as appropriate or undesirable depending on social and cultural factors as well as the mindsets of the individual members. The person may pick up drug usage from their family as an established habit or as a reaction to numerous systemic and familial mismatches.



Working closely with the person who is addicted to substances and their family is crucial in this regard. Several theories provide diverse explanations for substance use and addictive behaviours. According to the biology and illness models, addiction results from a person's biological and genetic susceptibility to it. It could not necessarily be treated as a disease. According to the evolutionary idea, people tend to act on their pleasant desires. People may repeat both healthy and bad compelling wants. Self-control is crucial if you want these desires to go in a positive direction. That kind of addictive activity is brought on by a lack of self-control. Addictive behaviours are viewed by learning theory as learnt habits (Orford et al., 2001).

According to the social learning hypothesis, modelling conduct is essential for the emergence of various addictive behaviours. It discusses how media, social relationships, and family have an impact on people's addiction processes. Operant training provides a much more comprehensive explanation for the persistence of addictive behaviours when coupled with the brain's reward system. After being exposed, the beneficial benefits and sensation of improved well-being may encourage the person to use the drugs repeatedly. Dopamine levels may need to be readjusted as a result of prolonged use, which forces the user to keep using the drug in order to feel happy. The classical conditioning theory describes how people develop different cues related to addictive behaviours, even if it does not significantly contribute to explaining the commencement of substance use among individuals (Jacob & Leonard, 1994).

The cognitive theories explain addiction when people's cognitive biases lead them to believe that drugs can help them in many ways to deal with their issues in life. Psychodynamics holds that ego deficits in people result in insufficient control over Id impulses, and that Id urges to gratify pleasure may include addictive behaviours. It also emphasises oral fixation, which might result in a thumb suck and later be replaced with different substances (Jacob & Leonard, 1994; Andrews et al., 1993; Ducci & Goldman, 2012).

## **2. Family Factors Associated With Initiation of Addictive Behaviours**

Numerous studies have shown that families with substance-using members tend to have greater rates of various behaviours that are addictive and substance usage. From several angles, it is possible to assess the families' contribution to this. First, the biological model of addiction suggests that heredity may play a significant role in addiction. The same genetic susceptibility of people may lead to an increase in the rate of substance use among the group. It supports its position by employing genetic and familial research to demonstrate the high incidence of the use of drugs among similar family members. Any first-degree relative who has used drugs or alcohol in the past is thought to have a greater chance of developing addiction disorders. Alcohol addiction in controlled families has a thrice higher likelihood of occurrence (Ducci & Goldman, 2012).

The illness model had flaws when it came to describing the effects of peer and social pressures and failed to clarify why many people who shared the same genetic link did not develop dependency, and vice versa. The most significant involvement of family members in substance use disorders may be explicable by the social learning hypothesis. When children are exposed frequently to senior family members using drugs, they may begin to imitate them and eventually form a habit of doing so. They could receive positive messages about different substances as a result of their very cheerful demeanour and the importance placed on drugs on special occasions. If they are not given what they need, youngsters will begin to behave in many ways like adults. Children may hear older people talk about reasons for using drugs such as being tense, apprehensive, worried, sleepless, and lacking confidence, as well as for enjoyment. For instance, it's quite typical for alcoholic males to excuse their drinking to their children by saying things like, "*Papa was so tired, so that's why he took some drink,*" or "*I got a promotion so I drank with my peers to share the joy.*" When children get older, they could also begin acting in ways that they learned from their familial environment. According to studies, parental substance usage has a significant impact on adolescents' substance intake, particularly their use of alcohol and tobacco. The majority of the time, fathers' and mothers' drug usage is positively correlated with boys and girls (Forney et al., 1989; Andrews, 1993, 1997; West & Hardy, 2005).

Both extremely strict and extremely liberal parental supervision have been demonstrated to hurt behaviour related to substance use. The perfect family will have a mechanism in place to recognise and keep an eye on behavioural trends. In this situation, negative as well as positive reinforcement are crucial. Families' ability to regulate their members can be said to have failed if harmful behaviours like addiction are not recognised and controlled. When one or more parents use drugs regularly, there is a higher likelihood that the children will do the same (Wilson, 1980; Baumrind, 1989; Lamborn et al., 1991; Steinberg et al., 1994; Walters, 1994; Velleman et al., 2005).

Addiction initiation and family functioning are two different problems that are connected. They have to do with relationships and family dynamics. The quality of close familial relationships—cohesion, warmth, communication, etc. is discussed in this relationship. The family structure is discussed in terms of things like joint or nuclear, single-parent, family size, etc. Studies found that factors related to relationships much more strongly influence drug-related behaviours (Coombs & Paulson, 1988; Piercy et al., 1991; Velleman et al., 2005).

Addiction-related actions can be a coping mechanism for managing unpleasant feelings as well as a way to build social networks when there is a lack of familial support and connection. All age groups' substance use was found to be consistently predicted by social support. Support and direction given during stressful times and challenging circumstances have been demonstrated to be an inhibitor against starting certain drugs. It has been discovered that feeling supported by others is linked to people's improved coping abilities and defence against addictive behaviour. Addiction practises was linked to a lack of pro-social networks and perceived social support across all age groups (Dobkin et al., 2002; Lonczak, 2007; Garmendia et al., 2008).

The greater prevalence of substance-using behaviours among offspring may also be the result of social effects. The production and consumption of many drugs are socially acceptable in many cultures. The use of marijuana, opium, and other alcohol in cultural and religious rituals is widespread throughout the world. During

celebrations and parties, drugs—especially alcohol and nicotine—are frequently used and approved. Alcohol use in particular is seen as a method to demonstrate friendliness and camaraderie. Additionally, many associate alcohol with happiness, social prestige, and affinity. In many cultures, both marijuana and alcohol are frequently utilised during religious blessing rites (Eckersley, 2005; UNODC, 2007; ICMR Bulletin, 2008; Tandon, 2015).

The kings of India encouraged warriors to drink particular types of alcohol because they thought it would help them gain bravery. In some regions of India, alcoholic drinks like toddy, arrack, and mahua are consumed, and many people think that consuming them in moderation is healthy and promotes good health. As a result, it was used for various family and social activities, with or without limitations for girls and children. Opium concoctions in a variety of forms were widely used in many Asian communities. They thought it was linked to improved sexual satisfaction, longevity, and excellent health. Opium medicines are frequently utilised to treat conditions brought on by stress. In India, cannabis is utilised for religious rituals and is revered as being highly divine. Additionally, a wide range of conditions are treated using cannabis products in Ayurvedic medicine in India. It is used to treat dyspepsia, pain, rheumatism, dysentery, diarrhoea, hysteria, and other conditions as a hypnotic, analgesic, and antispasmodic drug. To combat the summer heat, a beverage known as “Thandai” is made in northwest India from a variety of herbs, fruits, and cannabis. These circumstances frequently provide an opportunity for people to engage in their initial drug experiments (Chopra & Chopra 1957; Shukla, 1979; Abel, 1980; Chopra & Chopra, 1990; Ganguly et al 1995; Dorabjee & Samson, 2000; ICMR bulletin, 2008).

According to studies, socioeconomic status has a significant impact on substance use in a number of different ways. The social partying and drinking culture encourages a more accepting mindset towards numerous drugs, particularly alcohol. Working-class parents are unable to spend enough time with their kids. Loneliness causes a great deal of psychological discomfort and may encourage addictive habits. Parental repression might help to control the problem. Low-income families may

also be more likely to use drugs as a coping mechanism due to increased stress, a lack of access to alternatives, unemployment, bad parenting, and social isolation, in addition to cultural reasons (Hanson and Chen, 2007; Luthar and Goldstein, 2008; Huckle et al., 2010).

### **3. Family Factors Associated With Maintenance**

In many situations, elements associated with the family maintain addictive tendencies. Beginning with genetic and biological theories, it is believed that addictive behaviours are a result of genetic programming that is irreversible once it has occurred in an individual. Genetic loading within families may be a significant factor in the development and ongoing persistence of addictive behaviour. Neuroscientific ideas suggest that the brain's reward systems are crucial in sustaining addictive behaviours. However, these ideas are unable to account for individual variances, how people maintain abstinence, or the efforts of contemporary treatment advancements, as well as why everyone in a family does not develop addictive behaviour (Perring, 2011; Reilly et al., 2017).

More information on drug start is provided by modelling theory, which also has an impact on drug maintenance. The participants may gain knowledge of a variety of contexts connected to addictive habits, including social occasions, festivals, family events, etc. Many people persist with their habits because they believe it is never appropriate to refuse a drink or a cigarette in particular circumstances. Family members and friends who frequently experience such circumstances are more likely to continue engaging in addictive habits (Andrews et al., 1997).

The classical conditioning hypothesis primarily describes how individuals create various cues connected to substance use behaviour. In particular, alcohol, nicotine, cannabis, and other drugs may be significantly maintained by it. People may recognise substance usage as a factor that relieves unpleasant emotions and heightens happy sentiments as they go through life. Numerous circumstances might be recognised by them as cues for their behaviours. The usage of substances and

stressful conditions may help to lessen negative emotions. However, in other circumstances, such as during family reunions, the use of narcotics may be acceptable for heightening happy emotions. Cues are strongly linked to perpetuating addictive behaviour since they are linked to craving (Lamb et al., 2016).

Family member drug usage is significantly influenced by the nature of their interactions, particularly the connection between parents and children. It was discovered that tight relationships deterred addictive behaviour. When kids look up to their parents as role models, it may result in greater levels of pro-healthy behaviour and a decreased propensity to engage in antisocial behaviour (Kandel & Andrews, 1987; Bahr et al., 1995; Duncan et al., 1995; Velleman et al., 2005). Further, family communication is a complex topic that affects each member in a variety of ways. According to research by Brook et al., in 1990, Kosterman et al., in 1995, and Velleman et al., (2005), the quantity and nature of communication between members both verbal and nonverbal as well as the clarity of that communication, unclear expectations, inconsistency and contradictory messages, and conflicts were all found to be related to those members' addictive behaviours. Moreover, healthy outcomes were shown to be connected with expressions of warmth, support, clarity regarding positive expectations, consistency in messages, and moderate level control (Coie et al., 1993; Yoshikawa, 1994).

Possessing effective parenting techniques may reduce the likelihood that children may interact with troubled groups. Excessive control and leniency both have the potential to promote abnormal behaviour. It was anticipated that harsh punishment and criticism would have unfavourable effects. Children may be protected from addictive behaviours by parents who use positive reinforcement, consistent control, responsibility, modest demand, and self-efficiency appreciation.

As was already said, families' sociocultural contexts have a significant role in sustaining varied drug use and dependence. There could be a range of attitudes and opinions about different substances. It has been observed that opinions regarding the adverse consequences of various substances vary from location to place and among different ethnic groups. It has been discovered that members of particular ethnic

groups anticipate gains from substances that pertain to their personal and social lives. Numerous cultural items are frequently employed for therapeutic purposes as well. Families typically have a more accepting attitude towards such substances in these situations, which may help maintain substance use (Christiansen & Teahan, 1987; Johnstone, 1994; ICMR Bulletin, 2008).

#### **4. Family Factors Associated with Relapse and Recovery**

It was discovered that any issues with family relations increased the risk of relapse. Relapses may be caused by challenges with family boundaries, communication, cohesion, role dysfunctions, and behaviour problems, all of which may be managed well to promote recovery. Relapse risk is increased when family members and patients don't engage and communicate openly (Turner et al., 1993; Flora & Stalikas, 2013).

A significant indication of recovering from addictive illnesses was discovered to be a combination of strong social support and self-efficacy. The various supporting factors that make up social support are combined. Sometimes the support required may not just come from sticking together. Relapse risk is correlated with poor parent-adolescent interactions, poor management of family competencies, lack of parental affection, emotive reaction lack of parent engagement, and absence of parental care due to divorce or death (Dodgen & Shea, 2000; Fraser, 2002).

Family interventions are effective in cases with addictive behaviours, according to solid research. These treatments focus on the negative beliefs, attitudes, and behaviours that arise from dysfunctional families. Gaining better communication skills, looking into relationship obstacles, building trust, and addressing other co-morbidities are all ways to effect positive change. These elements improve compliance, which can provide positive outcomes and be extremely important in the recovery from addictive illnesses. It has also been discovered that providing appropriate psychoeducation is useful because it allows family members to understand disorders such as addiction in a way that considers the physical, psychological, and social domains. This type of therapy can also concentrate on the

family's support, and healthy coping mechanisms, emphasising the distinction between facilitating behaviour and recovery-supportive behaviour, and stressing the value of clear boundaries and effective communication. Activities that foster a sense of communal responsibility and feeling are typically encouraged (Nattala et al., 2010; Arria et al., 2013). Examples include family problem-solving, taking on extra responsibility when necessary, or performing activities together like cooking dinner, going on picnics, etc. It happens frequently that family members will want treatment from the patient to get them to cease their behaviours but the patient will still keep them. The patient's family frequently struggles to comprehend the value of shared accountability and protecting the sufferer from temptation. Like other behaviours, addictive ones can be both taught and unlearned. The influence of ongoing use of substances by other members of the family might cause the unlearned conduct to be relearned and lead to relapse (Marlatt & Gordon, 1985). Relapse in teenage substance addiction has been linked to parental rejection, substance use by parents and siblings, family strife, and divorce. Additionally, it has been shown that drug users are more likely than non-users to report having a difficult connection with their parents (Cattarello et al., 1995; Fraser, 2002; Van Der Westhuizen, 2007).

### **5. Family's Role in Preventing Addictive Disorders**

There are numerous successful family-based methods of substance misuse prevention and intervention. Some programmes concentrate primarily on teaching parents strategies to prevent their kids from engaging in addictive behaviours. The program covers parenting techniques, creating strong ties, communication skills, and encouraging prosocial behaviour. The teaching of family skills to parents and kids jointly is the emphasis of another sort of family-based prevention. These programmes place a strong emphasis on enhancing family functioning, communication, and control. Substance use may result from changes in harmful dynamics or a pathological family process, and preventing addictive behaviours may result from changing or eliminating such variables. Family therapy methods are helpful for persons whose relationships are having issues. The home-based therapies were centred on identifying family traits, attitudes, and behaviours that might affect



how addictive the members of the effective families behave. Parental guidance and support, the establishment of rules, communication, the accessibility and acceptability of substances, sociocultural variables, etc. are all approaches (Lochman & Van Den, 2002; Griffin et al., 2010).

## **6. Family Factors and Addictive Behaviours In Child and Adolescent Population**

Young people who have strong parental bonds are typically less influenced by their peers and engage in less substance-related behaviours. The likelihood that children would develop addiction illnesses may be inflated by parents who are overly indulgent and dictatorial (Velleman et al., 2005).

Beginning use of drugs amongst the adolescent population was found to be significantly predicted by parental substance use. Additionally, it was discovered that children of substance-using parents used a wider variety of drugs than their parents did. According to studies, adolescent alcohol consumption is maintained when parents continue to use drugs. Any favourable attitude towards substances has been linked to the continuation of substance abuse in its many forms. Parents' warnings were found to be effective in preventing the onset of addictive behaviour but ineffective in preventing the continuation of substance abuse (Kandel, 1974; Brook et al., 1986; Andrew et al., 1993; 1997).

All types of addictive behaviours, at all levels, are significantly influenced by peer support and social connectedness. Social networks and support have been demonstrated to be protective and beneficial in helping people deal with stressful situations more effectively. Despite this, social support has also been proven to be linked to people's acquisition of appropriate coping mechanisms. Low substance use has been linked to a high social support perception. For those with addictive illnesses, social support is a powerful predictor of treatment response and recovery (Frazier et al., 2000; Dobkin et al., 2002; Lin et al., 2011).

Other forms of addiction, such as internet and social media addiction have also been proven to be related to peer support and social connectivity. Social media

use may be growing to tap into social networks and support systems. Even though it has been demonstrated that using the internet can improve social connections, obsessive use of the internet has been linked to poorer indirect social connections and dysfunctional results. Families with divorced parents tend to be less warm, organised, and addicted to the Internet. Extreme internet users were shown to have less family communication than average users (Kraut et al., 2002; Lorento, 2002; Li and Zang, 2004; Ghasemi & Ahmadi, 2010; Li et al., 2014; Şenormancı et al., 2014; Habibi et al., 2015; McIntyre et al., 2015).

### **7. Geriatric Population**

According to studies, the demise of a spouse and a lack of support from others are the main causes of substance abuse in elderly persons. The elderly may start using drugs or alcohol as a coping mechanism after losing a companion because they may feel alone. Elderly people with more drinking issues have been observed to have less family support. Independently, social support, particularly after retirement, predicts the late start of addictive behaviour. According to studies, people who retire feel lonely and unproductive after losing their social networks. Along with this, there could also be issues with spouses and family connections for a variety of reasons. Addicts who feel isolated may turn to addictive habits alone or with friends when relatives are unable to provide them with enough support. High alcohol usage has been predicted to follow a stressor such as marital conflict and relationship unhappiness. The drinking habits and issues among the elderly were lower in those who received greater support from their wives. There is less evidence of addiction illnesses in married people. Elderly problem drinkers had fewer children, wives, extended family members, and resources (Pearlin & Schooler, 1978; Barr, 1985; Maeyers, 1985; Schonfeld & Dupree, 1991; Maeyers et al., 2002; Morgan & Brosi, 2007; Stelle & Scott, 2007).

### **8. Female Population**

A variety of factors are connected to female substance use throughout cultures and populations. Alcohol abuse in the family has been demonstrated to be a

major predictor. In such circumstances, females may start engaging in addictive behaviour at a young age, typically during adolescence. Relationship problems with a spouse or family are usually linked to late-onset addiction habits. Relationship problems with the husband, fidelity problems, and extramarital encounters are all very typical. Numerous studies have shown that women often begin using drugs or alcohol to handle a lack of support from their peers. Women with alcohol-related problems have frequently experienced divorce from their spouses and family members' abandonment. There is evidence that substance use among women is substantially correlated with all types of abuse. Due to several stigmas and societal taboos, women attempt to cope with their emotional troubles by engaging in addictive habits rather than disclosing their histories of abuse to others (Boyd & Mackey, 2000; Lee & Kim, 2000; Lim, 2002; Choi, 2003; 2005; Kim, 2006; Kim & Kim, 2008).

Additionally, it was discovered that men and women seek assistance differently. Families were shown to stigmatise and view women less favourably than they did men. This could lead to several disputes and battles within the family. Such a harsh attitude frequently encourages people to hide their substance use from their families. According to studies, women are frequently admitted to hospitals without their will and receive poor care from their families. Even severe repercussions like separation and divorce can result from the conflict (Lee & Kim, 2000; Jeong, 2003; Kim, & Kim, 2008).

Contrary to how it has traditionally been viewed, substance misuse frequently has an impact on the entire family. The majority of substance abusers, male and female, live in family situations, contrary to the stereotype of the "loner" alcoholic or drug addict. Additionally, the majority of people below the age of 35 either reside with one or both of their parents or maintain at least a once-a-week relationship with them (Wynne et al., 1997).

As a result, it's crucial to think about how family and the relationships within it affect the prevalence and incidence of substance misuse. Many instances illustrate how crucial it is to take the effects of substance misuse on families into account. One

illustration is the significant role that families frequently have in influencing the start of alcoholism or other substance abuse, the frequency with which it occurs, and the substances of choice. How a person interacts with their family, how they cope, and whether or not other family members use drugs or alcohol often influence whether or not they decide to use. The degree to whereby the family acts as a shield or cushion against substance abuse and its negative effects is another illustration of the importance of the family. Family members are more likely to use drugs and alcohol in households where they are frowned upon. A third illustration is the impact that alcohol and drug abuse frequently have on family members' interactions with and attitudes towards the family. Domestic violence and substance abuse are commonly connected. Additionally, it plays a significant role in family dissolution, divorce, and alienation of family members. These extremely negative effects of alcoholism and dependency on drugs on the abuser and the family highlight the significance of the family in comprehending the use of drugs and alcohol and addiction (Gutierrez, Russo & Urbanski, 1994; McCrady, Epstein, & Kahler, 1998).

Families are significant stakeholders who both support the course of change and gain from the improvement of a substance abuse problem, according to Copello and Orford (2002), who made this argument based on a review of the research. They concluded that there are many advantages to recognising and utilising the important function of families in assisting substance abusers in entering therapy, sustaining their involvement, improving their outcomes related to substance use, and minimising negative effects and harm to the family, including children. However, the fact that there are still obstacles preventing treatment from being extended to regularly and particularly including family members tempers their conclusion. While family members as well as other members of the support network are occasionally included in treatment, the vast majority of addiction programmes continue to be centred on the person who is a drinker or drug user. Additionally, they asserted that due to this concentration, research initiatives are typically centred on the person using substances rather than the possible outcomes of family participation.

The analysis of the literature here emphasises four main areas: Substance abuse is a concern for families since (1) it affects families, (2) it causes harm to families, (3) it can be perpetuated by families, and (4) it can be treated and recovered from by families. It is important to point out that the literature review in this work does not go into great detail about the different types of families or the stages of addiction treatment; rather, it concentrates on studies that look at how substance abuse affects families and the people who live in them. Additionally, the research literature on the connection between family and substance misuses tends to place less emphasis on other family relationships and structures, such as mature households, childless families or other changing family forms, and instead concentrates mostly on parent and child/adolescent difficulties. The conclusion of this work offers comprehensive suggestions for future research that specifically considers the family unit in addition to the framework and functions of raising children instead of one which views the family as a fundamental basis for understanding substance abuse. This is done in acknowledgement of a more inclusive sense of family (Copello and Orford, 2002).

## **9. Families and the Perpetuation of Substance Abuse**

### **i) Family Climate and Functioning**

A healthy family offers a setting that promotes the successful growth and safety of its members. This result represents a family setting that is safe, harmonious, and mutually supportive; one that is characterised by appropriate roles, efficient communication, regular display of good affect, and one that is founded on a common set of societal norms and values. In order for the family to work, family members must be emotionally connected to one another and capable of influencing one another's actions (Moss, Lynch, Hardie & Baron, 2002).

Functional family roles are frequently misrepresented or absent in families where addiction has taken place. For instance, children of alcoholic parents could get parentified and assume adult duties, which may prevent them from engaging in

activities or socialisation opportunities with their peers that are appropriate for their age (Haber, 2000).

It is possible to think of a family as an ecosystem with interdependencies among its members. According to this viewpoint, when one component of the system is altered or “damaged,” it affects the remaining components. Another aspect is that the family may change as a unit to protect and support the substance user, which could result in accommodating problematic family dynamics. The establishment of family regulations and practises that cover up family member-dependent behaviour are also common components of this adaptation (Stevens-Smith, 1998).

The possibility of a reciprocal impact between substance abuse and use along with other family member conduct is an additional consequence of a systemic perspective. For instance, Stewart and Brown (1993) contend that drug use in the family may both cause and result in problem conduct in adolescents. As a result, the end of adolescent drug use can result in improved family relationships, as well as increased interaction and encouragement for the adolescent. The beginning of substance misuse is typically accompanied by stress, which can be brought on by losses, problems with control or management, or even upheavals in the family (Bennett, 1995). As a result, it is widely known that families frequently play a crucial part in the development of an alcohol or drug addiction (Liddle & Dakof, 1995; Margolis & Zweben, 1998; Moore & Fraser, 2006; Moos, Finney & Cronkite, 1990; O’Farrell & Fals-Stewart, 2000) and its treatment (Edwards & Steinglass, 1995; cf. O’Farrell; 1993; Stanton & Shadish, 1997). The course of treatment and its results, it has both adverse and favourable effects. When substance misuse is eliminated as a problem, issues that may have remained concealed by substance usage may become apparent (Haber, 2000).

Steinglass et al., (1987), examined the status of alcohol use—abuse, transition to recovery, and recovery—affects the way families interact patterns and their adaptive reactions to circumstances and conditions related to the family’s use status.

## **ii) Substance-Affected Spouses**

Alcohol misuse is a cause of marital strain, domestic violence, and separation and divorce as well as a result of these events (Amato & Previti, 2003; Halford & Osgarby, 1993; Wilsnack, 1996). Exacerbation of alcohol misuse and unsuccessful sobriety are linked to stressful marital interactions (Halford & Osgarby, 1993; Kahler, McCrady & Epstein, 2003). According to McCrady & Epstein (1995), substance addicts frequently link up with or marry other substance abusers. The research finding reveals that inconsistency in a couple's substance usage is linked to a poorer quality marriage and more stress in the union (Fals-Stewart, Birchler, & O'Farrell, 1999; Mudar, Leonard & Soltysinski, 2001; Wilsnack & Wilsnack, 1993).

Alcohol addiction is linked to divorce and separation, yet it may be equally of a result as it is a sign that a marriage will end in divorce. Fortunately, for some people, getting married and starting a family may also act as a turning point for quitting drug use (Yamaguchi & Kandel, 1985). Further the author explained that, having a difficult time with your spouse or partner can make you want to start abusing alcohol and other drugs again or keep doing so (Sullivan, Wolk & Hartmann, 1992).

Narrating, fighting, financial pressures, and poor problem-solving skills are frequently cited as precursors to drug misuse. A trigger to continue using drugs can occasionally come from the abuser's resentment at attempts to intervene or limit their behaviour (Wynne et al., 1996). One spouse drinks a greater amount frequently than one of them can point to relationship distress or conflict when there are drinking spouses. (McCrady et al., 1998; Wilsnack, 1996) Partners and boyfriends are more likely to reject that their partner or spouse has a drinking problem or needs treatment. Most partners abusing alcohol will try to cut back on their use through unpleasant methods such as nagging, complaining, and threats (Thomas & Ager, 1993). These initiatives are frequently made occasionally or in an ad hoc manner, and they are typically ineffective, leading to unfavourable abuser reactions and aggravating an existing marriage conflict and disagreement. These negative effects may compound

the issue and lead to the abuser sneaking out of the house to drink or consume alcohol (McCrary & Epstein, 1995; McCrary et al., 1998).

### **iii) Substance-Affected Parents**

The chaotic family situations of parents who use drugs are usually described as having frequent house changes, little contact with the dads, and severe financial shortages for the children's basic requirements. Due to the chaos and volatility of these families, social support is frequently also insufficient or nonexistent (Harden, 1998). Many drug-dependent parents lack strong parenting role models and frequently feel unqualified to be parents. Despite these emotions, many parents who struggle with substance abuse still want to be excellent parents but require special training to get past their shortcomings and problems stemming from their drinking as well as other substance abuse (Juliana & Goodman, 1997). Chemical dependency can have major effects on a kid and on the parent's ability to complete her or his job as a good role model and the primary carer, to the extent that substance abuse compromises a parent's capacity to parent (Harden, 1998; Murray, 1989).

Parents with substance addiction issues frequently endure social exclusion and marginalisation, which exacerbates the issue. Due to their incapacitation from drug or alcohol use, their time spent obtaining substances, their time spent in treatment, or their time spent in jail or prison, they are frequently absent parents (Kumpfer, 1987) (Dunn, Tarter, Mezzich, Vanyukov, Kirisci & Kirillova, 2002). (Chaffin, Kelleher & Hollenberg, 1996; Hampton, Senatore & Gullota, 1998; Hien & Honeyman, 2000) Family dysfunction and the likelihood of abusive parenting behaviours, such as child abuse and neglect, are frequently linked to parental substance misuse. Additionally, there is research that suggests drug use may exacerbate a parent's inability to parent, which leads to more difficult parent-child relationships (Hans, Bernstein & Henson, 1999).

The co-occurrence of mental diseases and substance abuse has also received much research: It has been discovered that dysfunctional parenting and using of substances are all linked to depression, bipolar disorder, and generalised anxiety



disorders (Bays, 1990; Luthar et al., 1993). The initiation and progression of substance misuse amongst children and adolescents have both been linked to parenting practices and parenting styles. Youth substance addiction has been linked to parent-youth conflict, strict parenting (including severe physical discipline or verbal rebuke), inadequate supervision, inefficient control, permissiveness, and a lack of parental warmth (Griffin et al., 2000; Kumpfer, Alvarado & Whiteside, 2003; Lochman & Steenhoven, 2002; McGillicuddy, Rychtarik, Duquette & Morsheimer, 2001; Webb, Bray, Getz & Adams, 2002). According to Baumrind (1991), the parenting methods of mothers and fathers have differing consequences on how likely their offspring are to use substances

#### **iv) Substance - Affected Mothers**

Substance-affected women express higher levels of guilt, humiliation, and conflict over their marriage and parental responsibilities, and they frequently worry about losing both legal and physical custody of the children they have together. According to research by Davis (1994) and Kelley (1992), moms who use drugs or alcohol frequently feel inadequate and incompetent parents, relate poorly with their children, and view them as being unduly demanding (Kahler et al., 2003)

Some substance-using moms escalate their drug use to cope with their sense of inadequacies as mothers and their views of newborn rejection. Children reared by substance-abusing moms frequently have absent fathers (Davis, 1994), and occasionally these children may even be orphaned from their drug-dependent mothers. It's crucial to remember that substance abuse by mothers does not necessarily turn into poor parenting (Baker & Carson, 1999).

For instance, according to Suchman and Luthar (2000), the sole parenting factor directly linked to maternal addiction was insufficient parental involvement. In addition, parenting factors, such as autonomy control and setting boundaries may be better explained by factors other than substance abuse. However, there is a lot of data connecting bad parenting to drug and alcohol addiction. Parental deficiencies, such as unfavourable parenting practises, strict punishment, intolerance of child conduct,

and insensitivity to both children's needs and stage-specific developmental concerns, have been conclusively related to maternal drug addiction (Suchman & Luthar, 2000).

According to Brooks et al., (1994), maternal substance usage has a major impact on how children develop. Exposure to prenatal drugs is linked to higher instances of anxiety regarding parenting and child abuse. According to recent studies, pregnant women are consuming more alcohol than ever before (Ebrahim et al., 1998). Chemically dependent women frequently exhibit poor parenting abilities and methods for raising children (Davis, 1994; Fiks, Johnson & Rosen, 1985). According to research by Hien and Honeyman (2000) and Miller, Smyth, and Mudar (1999), drug usage is also linked to a higher likelihood of punitiveness and more harshness in mother disciplinary practices.

Drug-using mothers' lifestyles can occasionally be incompatible with effective parenting (Harden, 1998). A woman's ability to meet the psychological and cognitive needs of her children is likely to suffer significantly if she engages in aberrant or criminal activity, like prostitution or the sale of illegal narcotics. Additionally, being around violence and other traumatic experiences might make it harder for parents to adequately watch over and engage with their kids.

#### **v) Substance-Affected Fathers**

As opposed to substance-affected mothers, the function of substance-affected fathers in the family has not been adequately investigated. Fathers should be taken into consideration when doing substance abuse studies, according to McMahon and Rounsaville (2002). What was previously believed to be maternal impacts of substance usage on urban children have now been linked to absent, substance-abusing fathers (Frank, Brown, Johnson & Cabral, 2002).

According to studies by Eiden, Chavez, and Leonard (1999; Eiden & Leonard 2000), fathers who abuse alcohol are more sensitive to their young children's needs and behaviours. For instance, Noll, Zucker, Fitzgerald, and Curtis (1992) discovered that preschool-aged males with alcoholic fathers developed much less personally and

socially than control children. Paternal alcoholism has also been demonstrated to affect cognitive development. According to some studies, dads' drinking directly influences teenage drinking, whereas mothers' drinking does not appear to be a factor in children's alcohol usage (Zhang, Welte & Wieczorek, 1999).

#### **vi) Siblings**

In addition to providing drugs to their younger siblings, older siblings also frequently consume drugs with them (Needle, McCubbin, Wilson, Reineck, Lazar & Mederer, 1986). According to Brook, Whiteman, Gordon, and Cohen (1986), the use of drugs by their younger brothers was related to the use of drugs by their older brothers and the promotion of drug use. According to studies, the use of drugs by siblings may be a stronger predictor of their use than the use of drugs by parents or the views of parents towards substance abuse (Needle et al., 1986).

#### **vii) Extended Family Members**

It is important to note that in this time of changing family structures, members of extended families are also impacted by substance usage. According to some research (Orford et al., 2002; Ragin, Pilotti, Madry, Sage, Bingham & Primm, 2002), second-degree relatives have an impact on the nuclear family through substance addiction and are similarly affected by substance abuse in the nuclear family.

### **10. Substance Abuse Harms Families**

Family substance misuse is typically accompanied by other issues like mental illness, spousal abuse, financial hardships, housing needs, and living in unsafe neighbourhoods. A lack of cohesiveness, low frustration tolerance, excessive expectations from children, role reversal, solitude, and poor parenting abilities are typical in substance-abusing families and are related to negative family outcomes (Johnson & Leff, 1999). Incest, child maltreatment, and other harmful family behaviours have all been linked to substance abuse (Bays, 1990; Davis, 1994; Famularo).

### **i) Child Abuse and Neglect**

Numerous studies of samples of child abuse cases (Ammerman, Kolko, Kirisci, Blackson & Dawes, 1999; Kelley, 1992; Dore, Doris & Wright, 1995; Dunn et al., 2002; Magura & Laudet, 1996), parental substance use is frequently linked to child maltreatment. Additionally, when a parent suffers from a substance addiction disorder, there may be a higher risk of child maltreatment (Ammerman et al., 1999). Although inadequate parenting techniques, social exclusion, and the behaviour of the children are also likely contributors to substance-affected parents' emotional and physical abuse and disregard for their children (Ammerman et al., 1999; Kelley, 1992), in addition to parental stress and low frustration tolerance.

There is less effort put forth and less opportunity for good parenting in families where there is substance misuse (Dunn et al., 2002). Placement away from home, children are regularly taken away from their parents for a variety of reasons, including parental neglect and maltreatment resulting from substance misuse (Azzillessing & Olsen, 1996; Famularo et al., 1992; Kelley, 1992).

### **ii) Family Violence**

It is well known that substance misuse and family violence frequently coexist. In cases of serious violence, such as homicide, substance misuse is well-known to be a significant risk factor for family violence (Brookoff, O'Brien, Cook, Thompson & Williams, 1997; Easton, Swan & Sinha, 2000). Partner aggressiveness and substance addiction are linked (Kantor & Straus, 1989; Stuart, Moore, Ramsey, & Kahler, 2003; Bennett, Tolman, Rogalski & Srinivasaraghavan, 1994; Kahler, McCrady & Epstein, 2003; Kahler, McCrady & Epstein). In their evaluation of 52 studies on husband-to-wife violence, Hotaling and Sugarman (1986) discovered that alcohol usage was one of four reliable risk factors for violent husbands. According to other studies (Brown, Werk, Caplan, Shields & Seraganian, 1999; Brown, Werk, Caplan & Seraganian, 1998), the degree of conjugal violence is correlated with the severity of substance dependence.

### **iii) Substance-Affected Children**

Perhaps more than any other family member, children are impacted by substance misuse. According to a frequently cited statistic, one in every four American children below the age of 18 may be exposed to alcohol misuse or dependency in their household (Grant, 2000). Grant, 2000; Kelley & Fals-Stewart, et. al.,(2002) states that children of substance-abusing parents are at greater risk of developing emotional, behavioural, and/or social issues. According to clinical studies (Moss, Mezzich, Yao, Gavalier & Martin, 1995; West & Prinz, 1987), children of alcoholics are more likely than children of nonalcoholic parents to receive a childhood psychiatric disorder diagnosis. Children who grew up in families with one alcoholic parent are more likely to experience negative childhood events than children who grew up in homes with both alcoholic parents (Dube, Anda, Felitti, Croft, Edwards & Giles, 2001).

The effects of parental drug and alcohol misuse on a child can be quite detrimental. When their parents are under the influence of alcohol or other drugs, young children may have a difficult time understanding changes in their parents' temperament or behaviour. In addition to the potential social embarrassment and shame that a parent's substance abuse or its repercussions may cause for the child, such use, particularly when it involves illicit drugs, may result in involvement from law enforcement and other areas of the judicial system, as well as negative outcomes. Parental substance misuse may also have a profound emotional impact. Children may feel resentment towards their parents or worry about the things that will impact them. Children in the latency period frequently experience feelings of being abandoned, helplessness, hopelessness, and even guilt for not intervening to stop their parents' drug or alcohol use (Dore, Kauffman, & Nelson-Zlupko, 1996; Murray, 1989). According to Moos, Finney, and Cronkite (1990), children who have an alcoholic parent are more likely to experience psychological, behavioural, and academic issues.

Studies have demonstrated a link between parental alcohol misuse and young adult adjustment issues (Clair & Genest, 1987; Felitti et al., 1998) as well as juvenile

psychopathology (West & Prinz, 1987). Children's social and physical functioning is negatively impacted by parent relapse (Moos, Finney & Cronkite, 1990). Children who grew up in households that abuse drugs or alcohol and are dysfunctional frequently acquire unhealthy expectations about their future relationships. They struggle to accept authority, have issues with intimacy and trust, and struggle to maintain emotional equilibrium (Craig, 1993). They also have high expectations of themselves.

Murray (1989) observed that although assessing the disruption and connecting it to a particular action is challenging, parental drunkenness is likely disruptive to family life. Children's susceptibility to parental behaviour and the effects of substance misuse on them are probably influenced by a variety of environmental and social variables as well as the child's particular developmental stage.

#### **iv) Impact on Early Child Development**

Up to 10% of neonates may have been subjected to alcohol or drugs, according to recent studies (Azmitia, 2001). According to earlier estimates, the number of prenatal drug exposure cases varies between 350,000 and 739,200. Alarmingly, it has been estimated that at least 9.1 out of every 1,000 births, or about one in every 100 live births, occur as a result of foetal alcohol syndrome (FAS) and alcohol-related neurodevelopmental disorder (ARND). According to Azmitia (2001), FAS is the leading cause of mental impairment in children. Prenatal maternal drug use has been associated with poor growth, aberrant brain development, neurobehavioral deficits, and sensory and sensory-motor abnormalities (Chasnoff & Lowder, 1999; Dunn et al., 2002). For instance, cocaine usage during pregnancy has been directly connected to birth defects (Behnke, Eyler, Garvan, Wobie & Hou, 2002).

Alcohol and other drug use during pregnancy is widely believed to hurt children's subsequent development (Harden, 1998; Johnson & Leff, 1999). For instance, prenatal exposure to alcohol and marijuana has been shown to negatively

affect 10-year-olds' learning and memory abilities (Richardson, Ryan, Willford, Day & Goldschmidt, 2002). Similar cognitive issues have been discovered in several investigations (McNichol & Tash, 2001). According to Hawley, Halle, Drasin, and Thomas (1995), children of moms who used cocaine more frequently had issues with their cognitive, linguistic, and emotional development. However, it is unclear whether or not these and other developmental implications are directly related to early effects of substance abuse, such as altered brain chemistry (Azmitia, 2001), to effects of inadequate parenting and nurturing, or other social and developmental factors (Hans, 2002). This is true even though multiple studies have identified connections between parental alcohol abuse and negative development in children (Johnson & Leff, 1999). A "normal" course of development and the ensuing psychological and behavioural responses are denied to certain children because they may be "parentified" early in life by having to care for a "sick" parent (Murray, 1989).

#### **v) Early Childhood/Latency Age Children**

According to Dore et al., (1996), the effects of alcohol abuse by parents on young children include behavioural issues, depression, anxiety, hyperactivity, a lack of self-worth, peer hostility, poor academic achievement, and a diminished sense of self-efficacy. Lack of parental supervision and schoolwork monitoring may be linked to the effects of parental substance usage on cognitive functioning as they manifest in academic performance.

#### **vi) Adolescents**

There is a lot of evidence to suggest that attitudes towards drug use and parental substance use are important influences on adolescent substance use (Baer, Garmez, McLaughlin, Pokorny & Wernick, 1987; Brook, Brook, Whiteman, Gordon & Cohen, 1990; Chassin, Curran, Hussong & Colder, 1996; Li, Pentz & Chou, 2002; Thompson & Wilsnick, 1987). The absence of parental substance use, in contrast, has been found to act as a buffer to prevent teenage use of alcohol and other substances (Li, Pentz & Chou, 2002). Youth using alcohol and other drugs have been

substantially linked to parent-adolescent conflict (Baer et al., 1987; Hops, Tildesley, Lichtenstein, Ary & Sherman, 1990).

Alcohol and other substances are used by adolescents to defuse domestic conflict or to rebel against their parents' control (Thompson & Wilsnack, 1987). On the other hand, adolescent drug use is discouraged by happy family relationships, including parental love and support (Bowser & Word, 1993; Stewart & Brown, 1993). According to Brook, Whiteman, Gordon, and Cohen (1990), adolescent drug use is negatively connected with parent-adolescent relationships, which includes parental participation in setting boundaries, assertiveness, tenderness, and child-centeredness.

#### **vii) Adults Children of Substance Abusers**

Once children reach adulthood, the impacts of parental drug and alcohol abuse on them continue. Numerous COAs continue to be at risk for behavioural, psychosocial, cognitive, and neuropsychological problems far into adulthood, according to research on adult children of alcoholics (COAs) (Anda et al., 2002; Chassin, Pitts, DeLucia & Todd, 1999; Johnson & Leff, 1999; Scharff, Broida, Conway & Yue, 2004). In particular, COAs may face long-term impairment in regulating their self-esteem, maintaining interpersonal relationships, and managing their emotions of shame (Lewchanin & Sweeney, 1997).

### **11. Families as a Treatment and Recovery Resource**

In a thorough therapy programme, family difficulties must be addressed (Craig, 1993; Kelley & Fals-Stewart, 2002; McIntyre, 2004; Straussner, 2004). Family participation is frequently sought due to the essential function it has in getting substance abusers into treatment, getting involved with aftercare, preventing relapse and maintaining recovery (Costantini, Wermuth, Sorenson & Lyons, 1992; Gruber & Fleetwood, 2004; Gruber, Fleetwood & Harding, 2001; Knight & Simpson, 1996; Margolis & Zweben, 1998; McCrady et al., 1998; Ossip-Klein & Rychtarik, 1993; Stevens-Smith, 1998). According to the literature, parent – and family – focused intervention programmes can be successful in preventing and decreasing teen



substance misuse (Lochman & Steenhoven, 2002). According to Knight and Simpson (1996) and other studies (Gutierrez, Russo & Urbanski, 1994; Weiss, Martinez-Raga, Gryphon, Greenfield & Hufford, 1997), women who report receiving support from their partners or spouses are more likely to continue their treatment.

## **2.5 Family Resilience**

In every aspect of human life, there will undoubtedly be issues and challenges. Every person on our planet has challenges and troubles in their daily life. People will encounter challenges in various ways. Many people allow themselves to be “destroyed” by the failure to resolve challenges or find it challenging to resuscitate their lives, but some people may swiftly recover and reflect on the hardships they have faced. Popular terminology for the condition is resilience. Assuming that people have the resources to be able to handle their issues, the primary goal of health-related studies has evolved away from studying diseases, weaknesses, or susceptibility and towards exploring individual strengths since the 1970s.

The idea of resilience has drawn a lot of attention in the history of fostering this personal power. The idea of resilience is divided into two fields, physiology and psychology, by its historical beginnings. This idea is then well-known and has been established particularly in developmental psychopathology research, which demonstrates that there is a subset of kids who are nonetheless capable of flourishing in high-risk households according to their capabilities.

Science researchers who studied stress and how families deal with stress, emphasising personal and familial effort in dealing with the stressors, then came to adopt the notion of resilience in the 1990s. Resilience is one of the topics in positive psychology since it emphasises an individual’s strength and capacity to overcome challenges. Resilience is then examined from a variety of angles as a concept. Since the resilience notion was first proposed as a concept at the family level, the viewpoints on resilience have changed. According to conventional wisdom, a family’s resilience is the culmination of individual family members’ resilience. A

modern viewpoint on family resilience emphasises the interconnectedness of the family unit as a whole. The perspective also considers the interpersonal dynamics that help families flourish in challenging circumstances. A contrasting viewpoint on resilience in families as an attribute and family resiliency as a process is the major development in the notion of family resilience. The investigation is then divided into two sections by researchers McCubbin and McCubbin (2001).

McCubbin and McCubbin (2001) look at family resilience from a multidimensional perspective, looking at what makes a family resilient in times of adversity. On the other hand, Patterson uses the idea of family resilience using a process perspective as a researcher. This perspective is concerned with the family's capacity to actively mobilise forces throughout a crisis, allowing the family to restore its system to the state it was in before the stressful event or crisis. However, to achieve a holistic picture, recent research on family resilience frequently emphasises interaction from the perspective of nature and process. In theories and research about child development and psychological wellness, resilience has emerged as a key theme. There is undoubtedly a good argument for shifting the focus of resiliency from the individual to the family level. Nevertheless, focusing too much on the resiliency of those who can endure in dysfunctional homes will prevent researchers and practitioners from identifying the variables influencing resiliency in couples or families (Walsh, 1996).

When we examine personal resilience in a relational context, it can be seen that resilience manifests in a child who can overcome challenges thanks to the support and care provided by at least one parent or another adult in the child's environment. In the Kauai research, every tough kid has a minimum of a single person in their life who welcomes them without conditions. They need to be aware that there is somebody out there who will help them succeed in their endeavours and build their confidence and competence. Werner adds that the most important positive impact on children's growth and development has been determined to be adult care and companionship throughout challenging times in all research conducted

worldwide that focused on children with life challenges and difficulties. Experience, which is constructed by society, also has an impact on adaptation (Gfroer, 1987).

Another expert, Gfroer (1987), discovered that how a child perceives a significant emotional experience, like the absence of a father or a contentious divorce, has a substantial impact on the outcomes. One of many scholars, Kagan, believes that families might have a good mediating effect by passing along views and an awareness of what is occurring to them. The family unit is considered to be the most logical form of protection for its members. Despite having dysfunctional family and parenting systems, some traumatised individuals may be able to recover and demonstrate resilience (Ghasemi & Malek, 2010).

Additionally, a person's family structure may be an indicator of risk for them as children and a protective factor for them as adults. In contrast, the family structure can be quite dynamic, particularly about how the individual approaches the challenges in their life. Along with a family's role in a person's life, many other elements also come into play. This article will analyse these characteristics in several different ways, including by evaluating conceptual literature and prior research on family resilience. Based on the specific questions that the researchers have formulated, including (1) family resilience as a concept; (2) determinant factor of family resilience; (3) perspective in understanding family resilience; and (4) challenges in family resilience research, this article was written to gain a better understanding of family resilience as a whole concept.

### **1. Family Resilience as a Concept**

The idea of family resilience has advanced extremely quickly. This idea was developed in light of several family resilience studies that were carried out in various contexts. Resilience is seen as an attribute and a process, and it may be fully understood using two classifications, as was previously stated. These two viewpoints have evolved, and they can now work together to create an in-depth comprehension of family resilience. Family resilience can be viewed as a trait, which allows us to identify the protective element as the main factor that allows the family to endure

hardship and prosper. Positive attributes that might motivate families to recover from a crisis make up this protective element inside the family.

Family resilience, according to McCubbin and McCubbin (1988), is the capacity of a family to help solve problems by coming up with a solution and making family members more adaptable in times of adversity. Family resilience is an effort made by the entire family that results in flexibility and success under pressure, both from the present and the future. Resilient families can react constructively to these situations in a manner that is typically based on the context, the child's developmental stage, the combination of risk and protective variables, and the family's perspective on the issue (1995; Hawley et al.,).

Family attributes are traits and dimensions within the family. Everything will function properly in light of the issues faced. According to McCubbin and McCubbin (2001), family trauma is also defined as a cycle of positive behaviour that people and families develop in response to stressful situations to recover by upholding their unity as a unit and regaining the well-being of both the individual family members and the family as a whole. Additionally, the term "family capital for resilience" has been used to refer to familial qualities. The idea of family resilience as a family trait related to the family's capacity to support individual resilience serves as the foundation for focusing on safeguarding characteristics as a family trait.

Additionally, the family structure can both be an indicator of risk for family members when they are young and a protective factor later on after the same person has grown up. Recent research has started to shift from looking at family resilience to looking at individual resilience (Walsh, 1996, 1998). Even warmth, affection, emotional assistance, and entry as a family attribute are described by Patterson (2002). Family resilience, according to McCubbin and McCubbin (2001), is a result of both good behavioural patterns and the effective use of each family member's and the family's collective skills. To react to stressful and harmful circumstances, one needs positive attitudes and personal competencies. The welfare of individual family members as well as the welfare of the family as a whole is also maintained and improved. This affects the family's capacity to recover. Numerous additional

researchers disagree with the trait point of view advocated by some experts and contend that family resilience is an ongoing process. According to the process approach, a family's capacity for resilience is increased by how well it uses coping mechanisms to deal with stress, adversity, and life transitions (McCubbin & McCubbin, 2001).

The family's activities are carried out in a step-by-step fashion, from confronting issues to taking steps to solve them. Family reactions to crises are a product of many different factors coming together to provide families with a stronger, more powerful, and more confident sense of self as they build their problem-solving skills (Patterson, 2002). Walsh (2016), another expert who supports the process viewpoint, describes resilience as the capacity to endure and overcome adversity or disaster. Walsh characterises it as a dynamic process that includes effective crisis-related adaptation. In addition to helping families recover and grow based on their experiences with adversity, resilience helps families establish a good response to the crisis. Family resilience is the ability of families to recover from hardship and grow stronger and more independent. Therefore, it may be claimed that creating, enhancing, and maximising good reactions to crises and obstacles constitutes the proactive method of building resilience (Walsh, 2016).

According to Walsh, resiliency is a dynamic process with various elements that all work together to move in a specific direction until the family's ability to solve problems is reached. The issue itself might be seen from two perspectives: either as a challenge or as a risk or catastrophe. How the family moves forward in order to preserve its function and strengthen its capacity to deal with challenges they encounter both currently and in the future will depend on these two alternative viewpoints on the issue. Froma Walsh has continuously advanced the idea of family resilience through his research and studies since 1996. With the addition of the aspects of family resilience, Walsh takes into account a large portion of the preexisting idea. Family resilience supports the health and happiness of the whole family and helps guard against challenges that might impair family cohesion (Walsh, 2016).

## **2. Determinant Factors that Build Family Resilience**

Numerous elements contribute to family resilience, M. McCubbin and Associates (1999). According to Asten and Coatsworth (1998), several factors can increase family resilience: (1) the duration of the family's challenging circumstances; (2) the stage of life during which difficulties or crises occur; and (3) the internal or external resources families turn to for support when facing an issue or crisis. Masten and Coatsworth examine how families can cope with and get through this time of difficulty according to the nature of the stressors already in place, how families can create various processes tailored to the degree of difficulties they encounter, and how families can manage the issues by utilising the social support already in place.

Additionally, McCubbin & McCubbin (1999) utilised it to describe how protective and recovery variables help families become resilient. Families employ protective elements to keep their structure intact and functioning properly. How the family uses it determines how this protection factor works in many different ways. Furthermore, the aspect of recovery can be utilised by families to overcome difficulties and emerge stronger from crises. In this instance, the family's shown recovery process also significantly contributes to the explanation of how the family makes use of this recovery element to resolve the issues they face. Walsh (2016), on the other hand, uses the system approach in the family to explain how belief systems, organisational processes, and communications or problem-solving processes function in family systems.

The family is viewed as a unit that helps the system continue to operate properly. The family's beliefs affect their perspectives and coping mechanisms in times of crisis, which in turn influence any potential solutions (Walsh, 2016). A positive belief system emphasises finding solutions to problems, seeing the connections and room for improvement, enabling families to come together, and viewing the circumstance as a "normal" life issue. Families can assess the possibility of resources and form optimistic perspectives and expectations when things are normal. Organisational processes, the second primary phase, emphasises fostering family resilience through adaptability, connectivity, and recognition of resources.

The third process is communication or problem-solving processes, which emphasises creating open lines of communication within the family. These processes are thought to boost mutual respect and trust while also assisting the family in accepting individual differences and the freedom to express emotions.

A concept map framework is then presented by Walsh (2016) to identify and explain essential family processes that can lower stress in dealing with high-risk circumstances, healing, recovering from the crisis, and fostering family ties to deal with hardship over the long term. Two fundamental tenets form the foundation of this theory: (1) The individual is someone who will understand and learn a great deal from the family environment and social world, and (2) the entire family has the potential to be resilient, and this principle can be maximised by identifying and developing the key strengths and resources within the family.

Based on three crucial family resilience mechanisms Walsh outlined, Thompson & Han (1999) investigated factors that strengthened family resilience. The findings demonstrate that Walsh's hypothesised family resilience variables are present in the situation. No matter the ethnicity, every family has unique strengths, weaknesses, and risk tolerance levels. The most effective measures a family can take for rehabilitation and protection are not key elements. However, new literature studies and research evaluations have outlined the key characteristics of strong and resilient families. A good mindset, spirituality, peaceful family members, adaptability, communication within the family, money management, family time, leisure activities, rituals and routines, and social support are some of these elements.

### **3. Families as a Preventive Resource: Risk and Resiliency**

In order to effectively treat and prevent alcohol and other drug addiction, it is crucial to take into account the notions of "risk and resiliency" (McCubbin, McCubbin, Thompson & Han, 1999). Risk is the collection of elements that affect the likelihood that a person would use and become dependent on drugs. The ability to prevent or recover from the negative effects of alcohol or drug usage is referred to as resilience. The assessment of risk and resiliency in relation to families is significantly

more difficult but crucial to avoid or reduce the harmful impacts of substance misuse on both the person and the family. Family risk is greater than the sum of the risks for each family member (and, conversely, resilience or protective factors). Instead, it focuses on the contributions that family members make to the dynamics of the family, its functions, and the choice of the family as an entity (McCubbin, McCubbin, Thompson & Han, 1999).

Targeting family resilience variables has received more attention as a means of slowing the start and recurrence of teenage substance misuse. The assumption is that substance use among youths can be decreased or avoided by increasing family action factors, such as intergenerational bonding, participation of the family in social events with their children, and use of social services to address family or youth problems (Johnson, Bryant, Collins, Noe, Strader & Berbaum, 1998). According to Hawkins, Catalano and Miller (1992), family and family environment-related elements, such as (a) family use of drugs and alcohol and attitudes toward/permissiveness of use, (b) family behaviours and management of activities practises, (c) conflict within the family, and (d) poor family relationships, contributed to youth substance use. On the other hand, they identified protective characteristics for families and family environments, such as (a) high levels of parental attachment and family ties; (b) stable family environments; and (c) encouraging family environments. According to Brooks and colleagues (Brooks et al., 1994), family features may work as safeguarding factors, ideally for kids and teenagers.

They contend that parental involvement, good parenting, close supervision, and proactive parental intervention may lessen young people's initial substance use or habits that lead to serious alcohol or drug use. Children's social and emotional functioning has improved as a result of interventions that emphasise protective factor development through better parenting and family functioning (Atkan, Kumfer & Turner, 1996), and anti-social behaviour associated with adolescent substance use has decreased (Hogue, Liddle, Becker & Johnson-Leckrone, 2002).



## 2.6 Quality of Life

According to Andrews and Withey (1976), Campbell et al., (1976), Phillips (2006), Ventegodt & Merrick (2003), and Verdugo et al., (2005), Quality of Life (QOL) is conceptualised as a judgement that encompasses subjective assessments of one's life at a particular point in time, regulated by a variety of objective elements.

The term “*quality of life*” (QOL) refers to a multifaceted, subjective construct that includes impressions of both positive and negative (Cummins, 2005; Diener, 1994; Ware, 1987) facets of life at any particular time. Definitions of “subjective well-being” and “subjective quality of life” are not distinct. According to Andrews and Withey in 1976, Ryff and Singer in 1998, The WHOQOL Group in 1995, and Campbell et al., in 1976, subjective well-being can be thought of as an active participation in life that involves the expression of a broad spectrum of human behaviours, including painful experiences, pain, and conflict, as a part of and in reaction to intellectual pursuits, social relationships, emotional attachment, and mental well-being. According to Campbell et al., (1976), a life that is interesting, satisfying, and safe -- that is, the goodness of life -- is what contributes to a person's overall feeling of well-being.

These perspectives, or subjective assessments of life, are at their core an emphasis on the individual's appraisal of their life conditions and aspirations (Laudet et al., 2009; Veenhoven, 2010). This method gives an alternative viewpoint to the more typical clinical QOL assessments, where doctors typically concentrate on symptoms and the accompanying client/patient well-being (Laudet, 2011). According to Constanza et al., (2006), Cummins (2005), and Veenhoven (2000), evaluations of well-being, happiness, and psychological discomfort seem to be reliable predictors of the more general construct of QOL. In the realm of study on drug use and dependency, this is a relatively recent conceptualization of QOL that is broader than that connected with the examination of health-related QOL with its focus on pathology (Tracy et al., 2012).

According to Bowling (2005) and Keys et al., (2002), one's overall sense of well-being is an assessment of their life in terms of two important factors: satisfaction and affect (both positive as well as negative). Happiness is typically viewed as a short-term indicator of how much individuals enjoy what they do (Campbell et al., 1976; Radcliff, 2013), whereas contentment is a more stable indicator of how well a person's needs are met (Veenhoven, 2013). According to Bowling (2005), satisfaction and happiness are complementary indicators of well-being. Both can be viewed as "democratic" measures (Diener & Oishi, 2000), allowing individuals to evaluate their own lives without relying on the opinions of professionals (Blanc et al., 2014; Hamilton & Redmond, 2010; Lora, 2008; Plege & Hunt, 1997).

### **1. QOL and Drug Use**

Drug use can have an impact on a variety of facets of life, including social and other connections, employment potential, and physical and psychological functioning (Laudet, 2011; De Maeyer et al., 2013; 2010; Fakhoury & Priebe, 2002; Marini et al., 2013; Zubaran & Foresti, 2009). This begs the question of how much drug users gain the advantages they desire. How much does this happen if the goal of drug use is to elevate one's emotional state?

Alcohol, tobacco, cannabis, medications, and illicit opioids can alter mood, perception, cognition, and behaviour (Whelan, 2004), so they have the potential to cause harm. Psychoactive drug use is common, whether it be licit or illicit, particularly in young adults and adolescents (Australian Institute of Health and Welfare, 2011; European Monitoring Centre for Drugs and Drug Addiction, 2014; United Nations Office on Drugs and Crime, 2014; Ventegodt & Merrick, 2003; Gore et al.,

### **2. QOL of Dependent Treatment Populations**

A study of literature was done to find studies and reviews that looked at the quality of life of drug addicts receiving treatment. There were eight reviews of the literature. One of them examined the impact of treatment programmes on client

assessments of QOL, while the other two examined QOL metrics (Donovan et al., 2005; Luquiens et al., 2012). The remaining five evaluations were concerned with the quality of life (QOL) of various drug types' consumers. Three of these five reviews—Donovan et al., (2005), Foster et al., (1999), and Rudolf & Watts (2005)—examined the relationship between QOL and alcohol consumption. One review (Connor et al., 2006) looked at the quality of life (QOL) of alcohol and heroin users, and the other looked at the QOL of opioid users (De Maeyer et al., 2010).

The multi-dimensionality of the QOL assessments was a key conclusion of these reviews and more current investigations. In a new cross-sectional investigation of outpatient treatment participants (N=201), Miller et al., (2014) discovered that mental health and employment, but not the degree of dependency, were predictors of subjective well-being. In a study conducted in Belgium, De Maeyer et al., (2013) discovered that people with opioid dependence have varied QOL profiles. By opinions regarding safety, living circumstances, and social exclusion, these profiles were created. Additionally, treatment clients who reported participating in meaningful activities had considerably greater QOL than those who did not, according to Best et al., (2013) (N=10,470).

While improving QOL through abstinence is the ultimate goal of treatment (Laudet, 2011), studies have shown that improved QOL may transcend abstinence (Tracy et al., 2012; De Maeyer et al., 2010; Garner et al., 2014). According to Tiffany et al., (2012) and Laudet (2011), changes in QOL assessments appear to include perceived changes to subjective domains. These domains cover a variety of topics such as social interactions (Tracy et al., 2012; Marini et al., 2013; De Maeyer et al., 2013), extracurricular activities (Best et al., 2013), job (Marini et al., 2013), and housing circumstances.

These studies have a number of restrictions. Participants who use drugs habitually typically have other issues. People frequently ask for assistance when in a crisis, and this may be seen in poorer QOL assessments, according to Connors et al., (2001). These studies' conclusions only apply to users of drugs who are dependent and receiving treatment. Fewer drug users are dependent, as we can see from the

previous section. Poor QOL ratings cannot be conclusively linked to drug use per se or to the severe nature of their usage, which is dependency, because the research projects included in these analyses lacked comparative drug-using groups. These studies only looked at adult subjects. There were no references to children or young adults in the literature review.

### **i) Alcohol**

The evidence that is currently available on the QOL of adult users of alcohol points to a dose-response connection. Adults who “binge” drink have reported considerably lower health-related QOL than those who abstain or drink in moderation (Okoro et al., 2004; Paul et al., 2011). When compared to moderate drinkers in a similar age range, older drinkers (50+ years) who have cut back on their alcohol consumption also report a lower QOL (Kaplan et al., 2012). These researches, together with those on the quality of life of alcohol addicts during treatment, imply that the quantity of alcohol ingested may affect assessments of QOL (Foster et al., 1999; Donovan et al., 2005).

### **ii) Tobacco**

In four researches (McCarthy et al., 2002; Piper et al., 2012; Wang et al., 2014; Wilson et al., 1999), the quality of life (QOL) of tobacco users without chronic illnesses was assessed after quitting smoking. According to numerous studies (McCarthy et al., 2002; Wang et al., 2014; Wilson et al., 1999), quitting smoking improves QOL. Additionally, attempts to stop smoking have been linked to this connection (Piper et al., 2012). Enhancing QOL was linked to quitting smoking in all studies. In the initial study (McCarthy et al., 2002), the QOL of smokers as well as nonsmokers (N=254) was evaluated over time. Participants who had stopped smoking reported higher QOL than those who kept smoking. Researchers looked at improvements in satisfaction with life over three years following an abstinence attempt (N=1,504) in a different research (Piper et al., 2012). The study discovered that any attempt to quit improved QOL, with people who had given up smoking showing the biggest improvements.

#### **iv) Medications**

It is normal practice to take drugs to feel better (Fischer & Rehm, 2007). Drugs can improve QOL and aid in the management of disease symptoms, according to Cooper (2013). However, Spoth et al., (2008) have identified the extra-medical use of drugs as a new public health emergency. The sole study that appears to have been done on the QOL of those who utilise drugs contrary to prescription is almost thirty years old (Caplan et al., 1984). In this research, Caplan et al., (1984) discovered that valium usage was only marginally linked with QOL, although longitudinal studies revealed no difference in QOL between valium users and the general population. Compared to the general population, cannabis users typically have poorer QOL scores (Ventegodt & Merrick, 2003). This correlation was also discovered in research comparing non-dependent versus dependent cannabis users (Barnwell et al., 2006). There have also been reports of gender disparities. In a countrywide survey of 43,093 persons over the age of 18, Lev-Ran et al., (2012) discovered gender disparities in health-related QOL amongst cannabis users. Cannabis usage and dependence were linked to reduced self-reported mental health QOL among female users. Contrarily, research on cannabis use for medical purposes has indicated that users report improved QOL in comparison to QOL before use (Barnwell et al., 2006; Harris et al., 2000; Swift et al., 2005).

#### **v) Opioids**

To find research that looked at the QOL of those who inject opioids, a literature search was done. There were eight investigations on the quality of life (QOL) of drug injectors (PWID) who were not receiving treatment, had no blood-borne illnesses, and had no mental health issues (Table 1). NSPs (needle and syringe programmes) or respondent-driven sampling (snowballing or convenience sampling) were used to recruit participants. Heroin was the primary opioid of concern. To gauge QOL, numerous different metrics were employed. These measurements included the World Health Organisation QOL - (WHOQOL-BREF), the Personal Well-being Index (PWI), and the Injecting Drug Users QOL Scale (IDUQOL Scale). Australia (n=3), Canada (n=2), Ireland (n=1), Scotland (n=1), Brogly et al., (2003),

Hubley et al., (2005), India (n=2), Ireland (n=1), Scotland (n=1), and Ireland (n=1) were the countries where research have been conducted the most frequently. These researches emphasise how subjective QOL is. For PWID, suffering stigma and social exclusion, as well as one's health status, were significant variables influencing QOL assessments. Family, health, money, housing, and partnerships were the life categories most frequently chosen by participants as being crucial in determining their QOL in a large-sample study conducted in Australia (Dietze et al., 2010). According to McDonald et al., (2013), those who believed they had HCV had a lower quality of life than those PWID found to be HCV positive. Similar findings were made by Armstrong et al., (2013), who discovered that poorer QOL was positively connected with socioeconomic status, particularly problems with social isolation.

### **3. QOL of Adolescent & Young Adult Drug Users**

Studies frequently observed that drug use was linked with lowered QOL (Topolski et al., 2001; Vaez & LaFlamme, 2003), lowered subjective well-being (Phillips-Howard et al., 2010; Batki et al., 2009; Katja et al., 2002; Lanier, 2001), or dissatisfaction (Farhat et al., 2011; Murphy et al., 2005; Kuntsche & Gmel, 2004; Zullig et al., 2001; Sumnall et al., 2010). Only two research, however (Molnar et al., 2009; Clifford & Edmundson, 1991), discovered that drug usage may improve QOL in young adults or teenagers. In a cohort study of students in grades 11 through 21 conducted in 2001, Molnar et al., discovered that drug use was linked to higher subjective well-being, albeit the relationship between drug use and subjective well-being was moderated by an increase in negative outcomes.

### **4. QOL, Drug Type and Frequency of Use**

Regarding the relationship between QOL and drug kind or frequency of usage, the results were ambiguous. QOL or its indications were found to be adversely connected with a higher frequency of drug use in several types of research (Clifford & Edmundson, 1991; Farhat et al., 2011; Phillips-Howard et al., 2010; Sumnall et al., 2010; Topolski et al., 2001).

## 5. QOL, Dynamic Assessments

The third important question was whether and if so, how, QOL changes as a result of drug usage. Therefore, it is essential to determine the QOL of teenagers and young adults before use begins. This analysis revealed that no research had mentioned participant QOL before use. Two studies (Zullig et al., 2001; Sumnall et al., 2010) did discover a connection between QOL assessments and the age at which drug usage began (as determined retroactively). Sumnall et al., (2001) found that participants who first tried alcohol, cannabis, cocaine, or ecstasy before the age of 16 were significantly more likely to report feeling unsatisfied with their lives at the time of the study. The participants in the study were regular nightlife users aged 16 to 35 who were recruited in several European cities. Similar findings were made by Zullig et al., (2001), who discovered that the first use of alcohol before the age of 13 was substantially related to lower satisfaction with life at the point of the interview.

Some research used data on QOL and drug use from at least two-time points to look at participant response changes in QOL over time. These researches, by Gryphon et al., (2002), Mason & Spoth (2011), and Fergusson & Boden (2008), presented contradictory results. Positive subjective well-being at time one, according to Gryphon et al., (2002), was linked to less drug usage at time two. While Fergusson and Boden (2008) found that higher cannabis use was linked to later-life unhappiness, Mason and Spoth (2011) found that adolescent alcohol usage was not a predictor of later subjective well-being.

Some factors may have a moderating effect on the temporal connection (Swain et al., 2012; Schulenberg et al., 1996). Alcohol and cannabis usage were not linked to lower life satisfaction after controlling for fixed confounding factors and the variable “time” (Swain et al., 2012). Similar findings were made by Schulenberg et al., (2000), who discovered that drug use was positively connected with subjective well-being among college students but adversely associated with it among married and parent individuals. In a cohort study, Bogart et al., (2007) discovered that while the use of tobacco and “hard” drugs at the age of 18 was linked to decreased life

satisfaction at the age of 29, low income, poor health, and using tobacco in adulthood separately mediated this association (Bogart et al., 2007).

## **6. QOL of Drug Users in Community Settings**

It should come as no surprise that there is significantly less literature on the QOL of drug users in the community. Some research suggests that drug-dependent individuals' quality of life (QOL) is worse than that of cohorts free of drug use dependency (Donovan et al., 2005; Rudolf & Watts, 2005; Smith & Larson, 2003; Volk et al., 1997).

For over thirty years, QOL has been a topic of research and academic attention. The phrase is now often used in ordinary speech and has entered the general language. Interest groups, researchers, and physicians are now concerned about it as something significant and desired (Verdugo et al., 2005).

A variety of strategies and plans from international organisations, such as the World Health Organisation (WHO), in addition to various governmental bodies, have increasingly included QOL. Both those who "have it" and those who think others "should" have it view QOL as a crucial issue.

In chronically ill populations, where the emphasis is on health-related QOL, QOL assessments are widespread. To date, however, there has been little attention paid to the quality of life (QOL) of drug users (Laudet, 2011; Best et al., 2013; Assari & Jafari, 2010; Zubaran & Foresti, 2009; Tracy et al., 2012). The WHO's definition of QOL, states that it refers to "an individual's perception of their position in life in the context of the culture and value systems in which they live and about their goals, expectations, standards, and concerns" (The WHOQOL Group, 1995), this is surprising.

The reasons for and potential effects of drug usage on an individual's life are better understood when the person is the primary focus instead of the drug use. When formulating policies, making decisions, implementing programmes, and keeping



track of treatment outcomes, a deeper knowledge of the QOL experienced by drug users can be used (Dolan et al., 2011; Goldin et al., 2014).

The current perspectives on drug use emphasise risk (Coveney & Bunton, 2003; Moore, 2008; Mugford, 1988), drug use as a type of “pathology,” or drug use as a source of pleasure (Holt & Treloar, 2008; Measham, 2004). These viewpoints, however, are limited and focus more on the acute phase of consumption, which is frequently connected to drunkenness.

The overwhelming majority of those who use drugs are not represented in these treatment populations, according to Assari & Jafari (2010), Di Giusto & Treloar (2007), Perkonigg et al., (2006), Maremmani et al., (2007), Tracy et al., (2012), and Tracy et al., (2012). The majority of research on drug users gathered in community settings has been cross-sectional. Few of these research evaluated young people’s QOL, particularly how it related to drug use. We also are unaware if QOL varies with medicine kind or dosage frequency.

## **7. Making Judgements about QOL**

### **i) Unique Self-Reflections**

QOL judgements are individual self-reflections of personal viewpoints and experiences. This QOL approach focuses on the individual’s point of view (Fakhoury & Priebe, 2002; Awad et al., 1997; Blanc Windle, 2011).

Reflecting on and evaluating one’s ego (a sense of self), connections to others, level of independence, having a purpose in life, high self-esteem, and feeling in control of one’s immediate environment serve as the foundation for subjective assessments (Antonovsky, 1987; Ryff & Singer, 1998; Verdugo et al., 2005).

According to several studies, how people perceive their quality of life is not necessarily consistent with what their actual circumstances might indicate (Albrecht & Devlieger, 1999; Fellinghauer et al., 2012; Sprangers & Schwartz, 1999; McClimans et al., 2013). A person’s perceptions of their quality of life (QOL) may be made independent of their current or prospective future health status, the existence

of sickness, or symptoms of disease, contrary to the disability dilemma (Albrecht & Devlieger, 1999) (Cummins, 2005; Hensel et al., 2002).

When objective metrics could indicate that a person's QOL ought to be lower (Maremmani et al., 2007; Albrecht & Devlieger, 1999; Brown & Brown, 2005), the person may nonetheless perceive their QOL as satisfactory. The spectrum of QOL opinions, from poor to outstanding can be found in all populations and across age groups, for instance, even though populations with long-term health problems report lower QOL when compared to the general population (Albrecht & Devlieger, 1999; Fellinghauer et al., 2012; Clavarino, 1996).

This seems to go against common sense. If QOL is used to gauge treatment success (as it frequently is), it stands to reason that people in worse health will exhibit lower QOL. When forming assessments regarding QOL, other components also appear to be involved, even though changes in expectation may be affected when mood states are extremely labile, such as in people with psychosis, sadness, and pleasure (Gazalle et al., 2007; Voruganti et al., 2007). On the one hand, the finding that subjective QOL assessments are mainly independent of physical health markers raises concerns about the use of QOL as an indicator of overall health (Brown & Brown, 2005; Maremmani et al., 2007). The face validity of self-reports or assessments of QOL, however, appears to be very good (Brockmann & Delhey, 2010; Parks et al., 2012; Ryan & Deci, 2001; Veenhoven, 1991).

## **ii) Happiness**

According to Campbell et al., (1976), happiness is a gauge of immediate impact that might change every day in reaction to ongoing events. There are various ways to define happiness (Veenhoven, 2012), but most people agree that it is more than just a reflection of one's material circumstances. Happiness is considered to be a key component of well-being (Veenhoven, 2012; Phillips, 2006). In addition to experiencing more desirable occurrences, cheerful people are also more likely to understand and remember ambiguous events favourably (Seidlitz & Deiner, 1993; Lyubomirsky et al., 2005; Tadic et al., 2013). Happiness 48 measures are regarded as

a valid and reliable assessment of the degree to which specific aspects of life are favourable at any given point in time (Veenhoven, 1991), despite the fact there remains work to be carried out in comprehending the temporal sequence of happiness (Brockmann & Delhey, 2010; Parks et al., 2012).

### **iii) Satisfaction**

Contrarily, satisfaction is an evaluation of one's goals, successes, and perception of reality about peers, societal standards, and one's values (Constanza et al., 2006; Proctor et al., 2009; Organisation for Economic Co-operation and Development, 2013). Happiness seems to fluctuate more than satisfaction does, and satisfaction is less likely to reflect or react to ongoing, short-term life events (Verdugo et al., 2005). Positive feelings and the lack of negative sensations were the best predictors of life satisfaction in the research of 222 college students. Even though their current emotional state was just mild, those with a strong sense of purpose in life reported higher levels of life satisfaction. Even after accounting for sensory enjoyment and affect balance, purpose in life still significantly predicted life and self-satisfaction, indicating that it is more than merely a hedonic variable (Diener et al., 2012). Due to the fact that everyone has different interests, goals, and priorities in life, several studies (Diener et al., 2013; Felce, 1997; Laudet, 2011) have suggested that life satisfaction is a crucial QOL criterion. The consistency of life satisfaction scores over time and contexts shows that similar data is used when people express their satisfaction and that consistent psychological mechanisms are at play (Diener et al., 2013). According to Diener et al., (2013) and Neugarten et al., (1961), the points of reference for this comparison cover a wide range of variables, including view on life, ambitions and accomplishments, social and economic situations and activities, as well as individual requirements. Measures of life satisfaction also have a strong track record of validity and reliability (Diener et al., 2013).

## **8. Psychological Distress**

Drug use disorders (SUD) are known to have a significant negative impact on mental functioning (Smith & Larson, 2003; Volk et al., 1997). There is no consensus regarding the co-occurrence of both aspects of well-being and distress and whether they are one dimension or two separate aspects of this construct (Beckie & Hayduk, 1997; Fayers & Hand, 1997). This notion is supported by the fact that there is a complex link between happiness and suffering (Andrews & Withey, 1976). According to Watson and Kendall (1989), high positive affect is thought to be related to how enjoyable life is, while low positive affect is thought to be related to depression. Low positive affect, on the contrary, has no significant connection with anxiety. In other words, experiencing and reporting poor satisfaction or well-being is associated with depression but not anxiety (Lavarino, 2000).

## **9. QOL is Multi-Dimensional**

The majority of scholars (Bowling, 2005; Bramston et al., 2005; Cummins, 2005; Felce, 1997; Schalock, 2004; Najman & Levine, 1981) concur that QOL is a multi-dimensional construct. Age, sex, socioeconomic status, employment, social (kids, relationships, and hobbies), health, and spiritual dimensions appear to interact in complex ways. QOL evaluations seem to transcend specific domains since they are multi-dimensional constructs (Zubaran & Foresti, 2009; Fakhoury & Priebe, 2002). The QOL of drug users may therefore reflect beyond the effects or outcomes of the quantity and/or amount of drugs consumed (Tiffany et al., 2012), according to certain arguments.

## **10. QOL is Dynamic**

Additionally, QOL evaluations frequently fluctuate as time passes and in reaction to various life circumstances. Individuals tend to change their notions of what constitutes QOL throughout their lives (Schwartz & Strack, 1999; Wood-Dauphinee, 1999). For instance, according to Blanchflower and Oswald (2008), subjective well-being seems to follow a 'u' shape throughout a person's life. These changes in QOL appear to result from people's values changing through time and in

different contexts (Muldoon et al., 1998; McClimans et al., 2013; Sansoni, 1995; Schwartz & Strack, 1999). According to Bonomi et al., (2000), McClimans et al., (2013), and Wood-Dauphinee (1999), a mix of circumstances, coping mechanisms, and expectations may have an impact on these adjustments.

## **2.7 Theoretical Framework**

This will concentrate on the most pertinent social work theories that provide a deeper knowledge of the intricate nature of substance abusers and their families in order to increase our knowledge of substance abusers and their families. The theories to be discussed include:

- 1. Family systems theory.**
- 2. Biopsychosocial theory.**
- 3. Social construction theory.**
- 4. Ecological Systems Perspective.**

In order to increase knowledge of substance addicts and their families while presenting a consistent overview of the intricacy of substance misuse, the ideas provided here were purposefully chosen as the most important ones. Other social work theories unquestionably have a place in our understanding of substance abusers.

The fundamental theory chosen is family systems theory because it provides the basic framework for using a psychosocial framework to view substance abusers from a larger perspective. The study of the family as a system can become chaotic when using a systems perspective. Families are made up of individuals who work together, are dependent on one another, and have ties to one another. A family is a complicated system, and any modifications to one component will affect other, interdependent components or members. The intricacy of families as an organised system is thus made more understandable through the use of family systems theory. The theory's applicability to substance abusers will be investigated to analyse the psychological perspective. According to the social construction of reality theory, each person's distinct perspective of drug users is based on his or her experiences

from inside their environment and culture. As a result, it offers a theoretical framework for examining how our present knowledge of substance abusers has evolved through time.

These theories were selected because they provide a thorough understanding of drug users and their families from a more general biopsychosocial standpoint.

### **1. Family Systems Theory**

Ludwig von Bertalanffy's general systems theory evolved into a subfield known as family systems theory (Von Bertalanffy, 1968). A fundamental understanding of general systems theory is required to completely comprehend family systems theory. General systems theory argued that organisms are complex, dynamic, and organised, in contrast to the mechanistic theories that were popular in the middle of the twentieth century (Von Bertalanffy, 1968).

A broad systems approach examines and focuses on how the fundamental parts of a system connect to build the system as a whole. The emphasis of a systems approach is not just on the individual elements, but rather on how each part is interconnected, interdependent, and interrelated. When viewing a system from a systems viewpoint, it is important to consider how every change in one component of a system might have an impact on other components, which in turn can have an impact on the initial component. Thus, according to general systems theory, a comprehensive perspective is required to properly comprehend all of the dynamics at play in any given scenario (Von Bertalanffy, 1968). A system is described as a collection of items with connections between them and their qualities (Hall & Fagan, in Barker, 2007). Since almost any combination of components will satisfy these requirements, a more intricate definition was required for a live system like a cell or individual creature.

An appropriate substitute is the general systems viewpoint proposed by Bertalanffy. The family is generally accepted to be "an example of an open, ongoing, goal-seeking, self-regulating social system and that it shares the features of all such systems" in recent years (Broderick, 1993). Additionally, certain characteristics set a

family apart from other social systems, such as how gender and generation are organised inside the family. The psychobiological characteristics of each family member (such as gender, age, health, fertility, temperament), the family's sociocultural position in the larger society, and the family's size, life stage, and complexity, among other factors, all contribute to the uniqueness of each family (Broderick, 1993). In conclusion, a thorough explanation of the family systems theoretical framework contends that "...individual behaviours of men and women are best understood in the context of their reciprocal interactions and systemic relationships" (Peterson et al., 2006).

### **Central premises of family systems theory**

The structure and dynamic character of the family system are the main tenets of family systems theory, which will be covered in this section. There will also be definitions provided for key terminology associated with each main idea.

### **Organization of family systems**

#### **i) Holism**

The foundation of family systems theory is the idea that families self-organize in ways that enable them to meet the demands of their various members while also overcoming the problems and chores of daily living (Broderick, 1993). This organisational principle is grounded in the idea of holism. As a result, from the viewpoint of family systems, one will concentrate on the family as a whole rather than only on its component sections or individual family members. As stated by Aristotle and others, the whole is more than the sum of its parts and possesses attributes that cannot be inferred from the total of the traits of its constituent parts. According to Jackson (1965), measurements that "...do not simply sum up individuals into a family unit; we need to measure the characteristics of the supra-individual family unit" are necessary. According to family systems theory, communication and interaction between all family members should be investigated in order to comprehend the family system as a whole (Broderick, 1993). As a result,

the family system is understood to be the product of all individual members working together.

**ii) Hierarchies**

Families organise themselves into hierarchies, or more manageable units or subsystems, according to the family systems theory (Minuchin, 1974). Subsystems are frequently developed and arranged based on gender or generation. Three main subsystems are distinguished in family systems theory: the marital (couple), parental, and sibling subsystems. Each subsystem typically consists of people who collaborate to carry out the necessary subsystem-specific activities. When the boundaries between subsystems are crossed and individuals from one subsystem move into another, as happens, for instance, when a child is involved in marital matters, families have been reported to face difficulties (Minuchin, 1974; Minuchin, Rossman & Baker, 1978).

**iii) Boundaries**

Family members establish boundaries between what is internal to and a part of the family system and what is external to and not a part of the family system when they organise themselves into a hierarchy (Broderick & Smith, 1979). In the family system, boundaries are established between subsystems and at every level (Broderick & Smith, 1979; Fleming, 2003). Families vary in the degree to which their boundaries are permeable, with some being open-minded and others being more closed. Boundaries govern the flow of information inside and between families; once more, some families are more permeable and permit knowledge to flow without restriction, whereas other families may rigorously limit the information that may be shared with those outside the family system. The permeability of boundaries can also fluctuate depending on the age and needs of family members, with adolescents and young adults pushing for more independence and permeability in the family system as an example (Broderick, 1993; Fleming, 2003).



#### **iv) Interdependence**

All of the individual family members and the various subsystems that make up the family system are intertwined and have an impact on one another when families organise themselves into a family system (Von Bertalanffy, 1975; Whitchurch & Constantine, 1993).

#### **Dynamic nature of family systems**

Families are dynamic by nature, with tactics and patterns that direct how they interact with one another (Broderick, 1993; Fleming, 2003). This is another fundamental tenet of the family systems theory. Families are dynamic, which gives them the flexibility to adjust to the shifting circumstances of everyday life and to support the personal growth of each family member. Families' dynamic nature can also be explained by referring to them as open, in-progress systems, where "open" refers to a flow of information and energy within the family system and its surroundings and "ongoing" emphasises the possibility of change over time (Broderick, 1993).

#### **i) Equilibrium**

Families must adjust to short-term difficulties and adjustments as well as daily activities and occurrences. The idea of equilibrium is used to describe how families always work to strike an equilibrium between the resources at their disposal and the obstacles they face (Broderick, 1993; Fleming, 2003). In order to achieve a sense of balance or homeostasis, the family makes an effort to maintain it (Bradshaw, 1988). If this goal is not achieved, the family might have to adjust its techniques and regulations in order to achieve this goal. Steinglass (1987) makes use of the term "morphostasis," which refers to the family system's capacity to preserve its organisational structure in the face of difficulties. On the contrary, morphogenesis alludes to the system's capacity to develop and evolve gradually to adjust to the family's changing requirements. In order to maintain a balance between being stable and allowing change, there is a continuous dynamic conflict in all family systems (Broderick & Smith, 1979).

## **ii) Feedback loops**

According to the family systems theory, a “feedback loop” is a specific word for the patterns or channels of interaction that help families achieve morphostasis or morphogenesis (Broderick, 1993; Fleming, 2003). Positive feedback cycles are interactional patterns that promote the system’s growth. Homeostasis is maintained by patterns of interaction known as negative feedback loops. The terms positive and negative should not be taken to mean nice or evil, as they are neutral (Fleming, 2003).

## **iii) Goal orientation**

Families are seen as goal-oriented from the perspective of family systems because they work to achieve particular goals (Broderick, 1993; Fleming, 2003). Goals can grow more or less achievable through interaction patterns, whether through positive or negative feedback loops. Equifinality is the ability of a family system to achieve the same ends through several paths (Fleming, 2003). The same starting point can therefore lead to various conceivable results, whereas various possible paths can lead to the same outcome.

## **Application of Family Systems Theory to Substance Abusers**

Since families are made up of interdependent and interrelated individuals, a systems viewpoint can be usefully used in the study of the family as a system of interconnected individuals (Sanders & Tennant, 1994 in Peterson, 2002). The relevance of groups and their impact on specific individuals is emphasised by general systems theory. We are all part of a complex web of social systems. These layered social structures might take the form of families, groups, communities, societies, cultures, etc. This idea holds that we can only comprehend individual behaviour by taking these social impacts into account.

In accordance with general systems theory, an individual’s addiction is brought on by wider social systems. Consider a single cell found within an organism to help clarify this occasionally perplexing idea. Understanding the tissue, organ,

organ system, and body in which the cell is functioning is necessary to comprehend a single cell's behaviour.

According to the notion of systems, harmony and balance are maintained by all systems. The saying, "*Don't rock the boat*" perfectly captures the requirement for a system to remain in equilibrium. Therefore, every person inside a specific system contributes to keeping that balance. However, if a system's natural equilibrium (status quo) is dysfunctional, the system works to keep it that way. For lack of a better phrase, it would "*rock the boat*" if we attempted to make the systems work better. This is how some dysfunctional systems can encourage and support some members of that system's population who engage in addictive behaviour. The primary system of interest in addiction is the family system.

Families function to maintain equilibrium, much like all systems. Typically, this involves actions and demands to prevent animosity, aggressiveness, conflict, and other things that cause discord. It might be expensive to keep this equilibrium in place. Every member of the family is impacted when someone in the family tries to stop abusing drugs or alcohol. Recovery, in other words, "*rocks the boat*".

Family therapy that assesses the family structure is a necessary part of recovery. This assessment helps to reveal unseen factors that support ongoing dysfunction. These factors have fostered addiction's growth. Family members collaborate to develop a healthier family system that does not encourage addiction after these forces have been acknowledged. For instance, if mum is lonely, she might drink in the evening. She manages to raise her three kids alone in this way. Her husband, however, spends most of his time watching television. Every time her spouse criticises her for drinking, a fight breaks out. Mom increases her drinking as a result of this unsettling tension, and the vicious cycle continues. A systems approach would advise the husband to put off watching TV until the kids are all in bed and have finished their schoolwork. The therapist can suggest that the husband and wife spend some time together doing something they both want to do in the evening. These activities aid in keeping the family system's functional balance.

## **2. Biopsychosocial Theory**

The biological, psychological, and social theories are all combined in the biopsychosocial theory. The concept that problems are simultaneously biological, psychological, and social is referred to as biopsychosocial. In essence, there are no biological issues without psychosocial ramifications, and vice versa (Cook, 1987; Greil, 1991; McDaniel, Hepworth, Doherty, 1992).

### **Application of Biopsychosocial Theory to Substance Abusers**

The biopsychosocial model of addiction offers a comprehensive, multi-dimensional understanding of the condition. Rather than having a single cause, addiction is influenced by a variety of biological, psychological, and social factors. The risk of addiction is influenced by genetics, biology, mental health issues, trauma, societal norms, and accessibility.

It is reasonable that many people are curious about the root of addiction given the toll that addiction has on sufferers, their families, communities, and society as a whole. Why does one individual become compulsively addicted to using drugs despite the grave repercussions, but the other can take drugs sometimes without losing control?

No of a person's moral fibre, integrity, or character, addiction can nonetheless happen to them. Many people believed, decades ago, that morally dubious people made horrible decisions that led to addiction. But the scientific study has long refuted that viewpoint. It is now understood that biology is crucial to the condition. The American Medical Association classified alcoholism as a disease in 1956 and recommended using both medical and psychosocial methods to treat the condition (Mann et al., 2000).

However, taking one's biological composition into account has its limitations, and research has shown that addiction is not a straightforward problem. There is no genetic variant or "addiction gene" that can fully explain the variety of addiction experiences. Rather, it is now understood that a variety of factors have a role in the

emergence of addiction. The ultimate line is that there are probably just as many ways to become an addict as there are addicts, according to Grisel (2019).

### **The Biopsychosocial Model**

The biopsychosocial model of addiction provides the complex conceptualization that the multifarious condition requires (Marlatt & Baer, 1988). We now know that there are a number of elements that influence someone's susceptibility to addiction rather than identifying one single factor that causes addiction. Some characteristics (like the way drugs of abuse activate the reward system) are universal. However, a lot of other factors are unique to each person, such as how strongly they perceive rewards and how well their brain's mesolimbic dopaminergic system is functioning. The biopsychosocial model offers a way to take into account the numerous variables that can raise the risk of addiction. The model has the following dimensions:

#### **i) The Meaning of "Bio"**

Biology and genetics have a role, but they are not the only factors. Despite the lack of an "addiction gene" that can be used to categorically determine if a person is at risk for addiction, twin studies, adoption studies, family studies, as well as epigenetic research have all shown that addiction has a genetic component. People who are genetically inclined to addiction have a higher risk of developing addiction throughout their lives. Numerous theories have been proposed to explain this inherited propensity, including the Reward Deficiency Syndrome (Blum et al., 1996; Blum et al., 2014), which holds that some people are born with underactive reward circuitry (also known as hypodopaminergic functioning), which predisposes them to the rewarding effects of drugs of abuse (Febo et al., 2017).

Dopamine, opioids, GABA, serotonin, endocannabinoids, glutamate, and many more neurotransmitters are also implicated in the sensation of reward (Blum et al., 2020). Therefore, a tendency to addiction may result from deficits in any one of these neurochemical combinations. It is significant to remember that each person will likely respond to the rewarding experience uniquely. This insight should encourage

us to have compassion for folks who are addicted because it is highly likely that other people do not completely understand how drugs affect them.

## **ii) The Meaning of “Psycho”**

The psychological makeup of a person also influences their likelihood of addiction, in addition to heredity. This factor covers a wide range of topics, such as personality traits (such as sensation-seeking and impulsivity), mental health issues (such as anxiety and depression), psychological concepts (such as self-esteem and self-worth), and the psychological effects of a person’s life experiences (such as trauma). Some people can be more susceptible to the rewarding benefits of substances of abuse as they are working so hard to control unpleasant emotions. According to studies (Dube et al., 2002, 2003; Giordano et al., 2016), trauma and addiction have a strong correlation. Indeed, Felitti et al., (1998) discovered that having more ACEs increased the likelihood of later using drugs and alcohol in the initial Adverse Childhood Experiences (ACEs) study. A dysregulated stress response is one interpretation of this trend, which is brought on by the toxic stress brought on by trauma. Stress hormones like cortisol and adrenaline are consistently raised in a person’s body (Burke Harris, 2018; van der Kolk, 2014).

The usage of drugs may be an effective approach for these people to control their ongoing hyperarousal, hypervigilance, and anxiety (Felitti et al., 1998). Therefore, a variety of psychological traits and experiences can raise the likelihood of abusing drugs to regulate emotions or change how one feels.

## **iii) The Meaning of “Social”**

The social environment is the third component of the biopsychosocial model. The sensation of addiction is influenced by social norms, accessibility, availability, legality, modelling, expectations, societal approbation, visibility, targeting techniques, and cultural beliefs. Social modelling, also known as learning via observation, can have an impact on an individual who has been exposed to drug use

at a young age. Furthermore, various places have particular social norms around drug usage (for example, “Everyone experiments with drugs a little in college”).

Additionally, some groups—especially those that are economically disadvantaged—are more aggressively targeted by alcohol and cigarette marketing and have greater access to illicit drugs than other areas (Primack et al., 2007; Rose et al., 2019). As a result, one’s risk of addiction is influenced by their social surroundings.

The biopsychosocial model of addiction (Marlatt & Baer, 1988) accounts for all of the various elements that influence a person’s risk for addiction. When considered as a whole, this model offers a holistic conception of addiction that recognises the intricate nature of the condition and offers treatment recommendations, which must also be comprehensive and multifaceted. The more we understand the biopsychosocial model, the more equipped we are to develop accurate empathy for persons who suffer from addiction and to work towards successful prevention and treatment programmes.

### **3. Social Construction Theory**

According to this notion, interactions with others are the source of learning and development. It is based on the notion that one creates or establishes reality via relationships with society and culture. According to this notion, human development is a joint effort. Experiences that lead to learning are produced through one’s contact with the environment.

Social constructionist theory’s guiding assumptions regard knowledge as:

- 1) Not inborn: It is built on prior information and keeps changing as a result of conversations and experiences.
- 2) Produced by an active process: People pick up knowledge through actively interacting with the environment through communication, problem-solving, and teamwork.

- 3) Created through group interactions: One's surroundings and community are important determinants of development.
- 4) Personal: Every person interacts with the world specially and importantly.
- 5) Cognitive: Humans interpret and comprehend their surroundings on a personal level; therefore their knowledge only exists in their heads and is sometimes different from the realities of others.

### **Application of Social Construction Theory to Substance Abusers**

Coffee used to be a substance that was only used in the seedier parts of society. Today's wealthy socialites consume truckloads of what doctors at the turn of the 20th century called "poison" every day. In the 1940s and 1950s, smoking cigarettes came close to being a "must" in social situations. To spare the good, hard-working smokers the stigma of the addicted, the surgeon general was explicit in identifying smoking as a habit and not at all an addiction after it was discovered that cigarettes caused cancer.

Cigarettes, however, came into the pernicious category of addiction by the 1980s, and it didn't take long for laws to be created taxing and stigmatising persons suffering from the most recent socially built addiction.

Addiction is socially manufactured, relegating its sufferers arbitrarily to the periphery of society. Smokers went from being sophisticated and classy to being repulsive and subject to fines in just a few decades. Before the public became involved in the drug war, heroin and morphine tinctures could be found in local pharmacies, and the majority of "addicts" were law-abiding, gainfully employed, and contributing members of society. It is challenging to fully comprehend and appreciate the ramifications of the fact that drugs were lawful and there were no "epidemic" drug problems only a century ago without taking a deliberate pause. For the moral majority, the social myth of the helpless, sick addict is an opiate in and of itself.



The early 20th century's fear-based drug war tapped into people's concerns about a world that was changing quickly. Simple solutions to complex issues etherize unreasonable human concerns, and the illicit drug war is no exception. Instead of difficult socioeconomic issues that required attention, it was much more convenient to blame cocaine and opium for the rising tensions between races in the early 1900s. Minorities were simply caught up in drug-fueled crazes and not outraged by the pervasive social inequities.

After more than a century, it has become clear that banning substances had no effect on reducing drug use or social unrest and that criminalising altered levels of consciousness had the uncontested effect of making the United States the world leader in the incarceration of its citizens. As mentioned in various studies, although addictions are based on what authority figures consider to be aberrant behaviour, diseases are established on scientific discoveries.

It is past time for those in positions of authority to acknowledge that using drugs is not abnormal. With the use of various substances, the vast majority of people change their awareness every single day. Over 75% of Americans take at least one prescription medication, while the majority of people consume caffeine (or poison as it was known a century ago) every day. In actuality, using drugs or alcohol to alter consciousness is the usual, and abstaining completely is abnormal behaviour.

#### **4. Ecological Systems Theory**

This theory examines how a child develops in connection to the network of relationships that make up his or her surroundings. According to Bronfenbrenner's hypothesis, there are many "layers" of the environment that might affect a child's development. The term "bioecological systems theory" has recently been used to emphasise that a child's biology serves as her primary environment for development. The child's growth is fueled and guided by the interaction of elements in his biologically growing surroundings, his immediate family and community, and the social environment. Conflict or changes in one layer will have an impact on all the

others. The relationship between the child and their immediate surroundings as well as the larger environment must be examined to research a child's development.

The microsystem is the stratum nearest to the child and comprises the components with which the child comes into immediate contact, according to Bronfenbrenner's theory of the environment. The interactions and connections that a kid has with her immediate environment are included in the microsystem (Berk, 2000). The family, school, neighbourhood, or childcare contexts are examples of structures in the microsystem. The impact of interactions at this level can be felt both towards and away from the child. For instance, a child's parents may influence his beliefs and behaviour, but the child also influences the parent's behaviour and ideas. These are what Bronfenbrenner refers to as "*bi-directional influences*," and he demonstrates how they affect all environmental levels. The foundation of this theory is the relationship of structures both within and between layers. Bi-directional influences are the most potent and have the most effects on the child at the microsystem level. The core structures can still be impacted by interactions at higher levels, though. The layer known as the mesosystem connects the child's microsystem's structures (Berk, 2000). Examples include the relationship between a child's teacher and parents, their respective churches and neighbourhoods, etc. The exosystem is the layer of society outside of which children do not directly participate. By interacting with a structure in the child's microsystem, the structures in this layer affect the child's development (Berk, 2000). Examples include the work hours of parents or family-friendly resources available locally. Even while he may not be fully engaged at this level, the youngster nonetheless feels the effects of the contact with his system, whether they are favourable or harmful. The macrosystem is a layer that might be regarded as the child's environment's topmost layer. This layer is made up of cultural values, rules, and practises while not being a defined framework (Berk, 2000). The interactions between all other levels are cascaded by the impact of the bigger principles established by the macro system. For instance, a culture is less likely to offer resources to support parents if it holds the view that parents should bear sole responsibility for raising their children. The structures where the parents work are subsequently impacted by this. The microsystem of the child

has an impact on the parents' capacity or incapacity to fulfil this responsibility towards their offspring. The chronosystem is a system that takes into account how a child's environments relate to the passage of time. This system contains elements that can either be internal, like the physiological changes brought on by a child's ageing, or external, like the date of a parent's death. Older children may respond to environmental changes differently and may be better able to predict how those changes will affect them.

### **Ecological Systems Theory and Its Application in Family**

The family, peer group, and resources in the community, school, workplace, and other social systems can be understood as layered contexts for resilience from an ecosystem perspective. Walsh (2009) notes that cultural and spiritual resources can help families remain resilient, particularly those who are dealing with prejudice and socioeconomic challenges (Boyd-Franklin & Karger, 2012; Kirmayer, Dandeneau, Marshall, Phillips & Williamson, 2011). Strong social effects affect families in more subtle ways than only outside forces or variables. As family members navigate and manage their connection within their social environment, risks are countered and resources are mobilised through active agency in family transactional processes (Ungar, 2010).

Understanding and promoting resilience requires a developmental perspective. Adversity's effects vary over time, with changing circumstances and in relation to the passing of individual and family life cycles.

### **Emerging Challenges and Resilient Pathways over Time**

Most large stressors don't just include one short-term incident; rather, they involve a complex web of shifting circumstances with a history and a route for the future (Rutter, 1987). For instance, risk and resilience associated with divorce involve family processes over time, such as the escalation of predivorce tensions, separation, and legal divorce and custody agreements, as well as the restructuring of households and realignment of parent-child relationships (Greene, Anderson, Forgatch, DeGarmo, & Hetherington, 2012; Walsh, 2016a). The majority of kids and

their families experience further upsetting transitions, including financial hardships, residence changes, parental remarriage or re-partnering, and the creation of stepfamilies. Children's resilience, according to longitudinal studies, is mostly dependent on supportive family processes throughout time, such as how parents and extended family members manage stress as they face these difficulties and creates supportive parenting networks among homes.

With the changing course of various illnesses, the psychological demands of a challenging circumstance, like a major sickness, may change (Rolland, 2018). For example, after a medical emergency, one may have a full recovery and return to normal life, a plateau of ongoing incapacity (as in the case of a stroke), a roller coaster of recovery and recurrences (as in the case of cancer), or a worsening course (as in the case of Alzheimer's disease). Given this complexity, different techniques may become more or less effective over time based on how well they match up with new problems.

It's critical to investigate how families tackle their challenging circumstances, their quick response, and their long-term coping mechanisms when evaluating family resilience. Initial attempts that are successful in the initial stages could rigidify and stop working later. For instance, when a father has a heart attack, the family must come together quickly to mobilise resources. However, if the family members persist in watching over the father even when he has recovered, it may become maladaptive. Families must change their focus in order to take care of other needs and priorities. A repeat will also be needed for adaptable readjustments. Therefore, family resilience requires numerous adaptational mechanisms that develop over time.

### **Cumulative Stressors**

Some families may weather a momentary crisis without breaking but crumble when faced with a series of long-lasting problems, such as a chronic disease, extreme poverty, unemployed status, or continuous, complex trauma in conflicts and war zones. Family functioning can be overwhelmed by a plethora of both internal and external stressors, increasing risk and vulnerability for subsequent issues (Patterson,

2002). For instance, the closure of a plant and the loss of jobs for wage workers can result in a series of issues, such as the loss of a crucial source of family income, which leads to protracted periods of unemployment, which increases the likelihood of housing instability, interpersonal conflict, and family dissolution. Workshops were created for displaced employees and their families as part of one community-based programme to lessen stress and increase employee and family resilience (Walsh, 2016b). The large group sessions were centred on overcoming obstacles caused by job transition stresses, including exchanging efficient strategies, easing relational tensions, realigning functional family roles, mobilising extended family members and other social and financial resources, and boosting support from family members for displaced workers' reemployment efforts.

### **Multigenerational Family Life Cycle**

According to McGoldrick, Garcia-Preto, and Carter (2015), human functioning is evaluated in terms of the family system as it progresses throughout the course of a person's life and across generations. Since family cultures, institutions, and gender interactions are becoming more diverse, complex, and flexible throughout an extended life trajectory, no family life cycle of successive phases should be taken as the standard (Walsh, 2012b). Families are negotiating previously unheard-of difficulties and experiencing a great deal of uncertainty about the future amid worldwide economic, social, political, and climate changes. According to a large body of research, children and families can thrive in a variety of secure, caring, and protective family arrangements (Biblarz & Savci, 2010; Lansford, Ceballo, Abby & Stewart, 2001). However, over time, it becomes more possible for people and their kids to experience a variety of houses and family arrangements, necessitating adaptability to overcome adaptational obstacles.

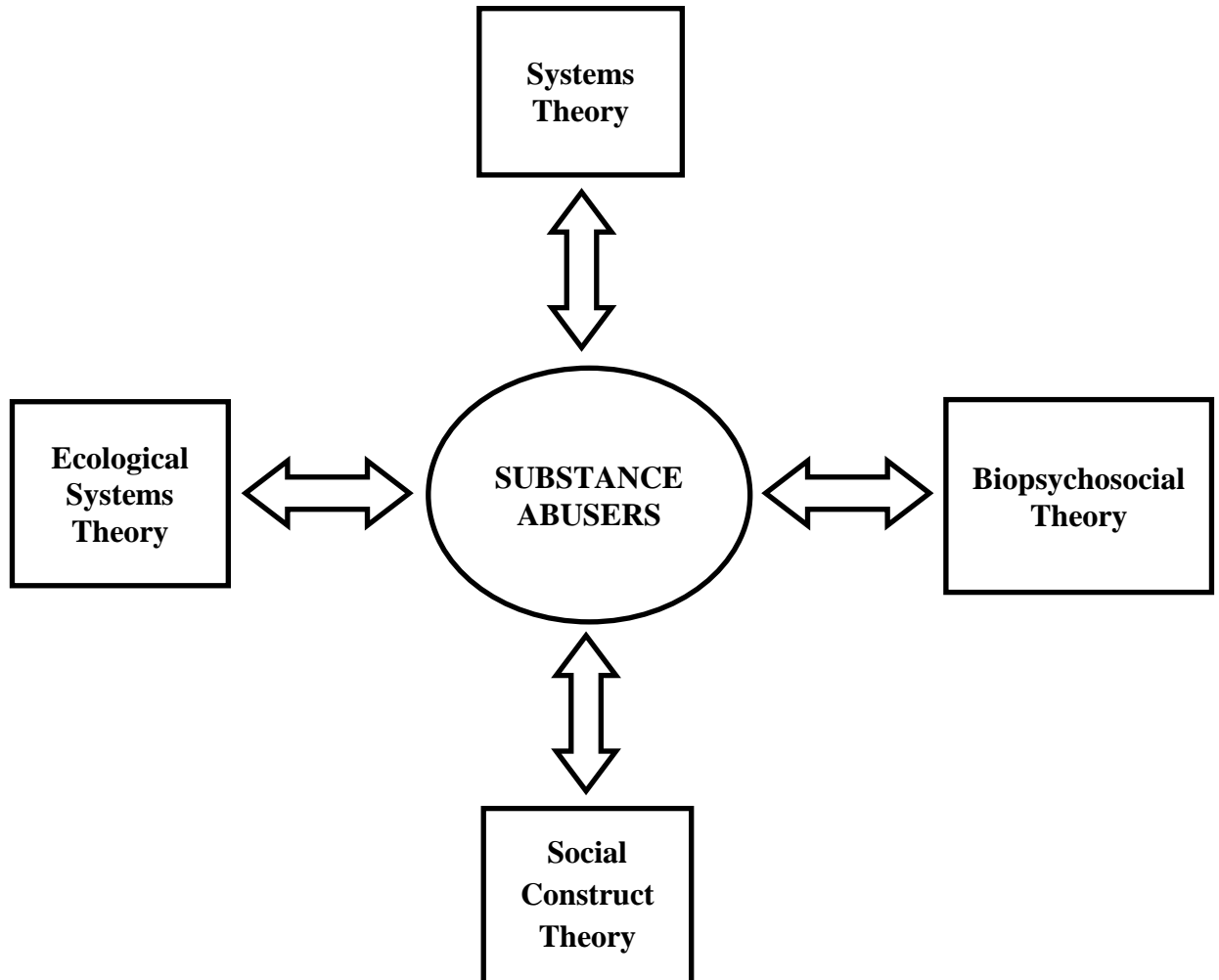
A family resilience lens emphasises response to significant events and substantial transformations across the family life cycle. This involves unforeseen issues with foreseeable, typical transitions, like the birth of a kid with impairments, as well as with extremely upsetting situations, such as the untimely passing of a parent who was raising a child. Frequently, extremely difficult family events or

changes coincide with the onset of signs in a family member (Walsh, 2016b). To organise relationship knowledge, track system patterns, and direct action, resilience-oriented genograms (diagrams of family relationships) and family timelines (noting significant events and stressors) are effective (McGoldrick et al., 2008). Connections are examined, for instance, when a son's school abandonment occurs after his father loses his job. Children who experience emotional or behavioural issues frequently also experience anxiety-inducing interruptions, such as parental divorce, imprisonment, or service deployment, which may cause changes in the family's established boundaries and roles. The effects on youngsters are probably going to alter depending on the important difficulties at various developmental stages.

Losses for a family can take many different forms (Walsh, 2013, in press), and they can affect not just specific people and relationships but also vital role functions (e.g., breadwinner, carer), financial stability, houses, and communities after a big tragedy, as well as future hopes and goals. By means of shared recognition, meaning-making, and shared grieving processes, facilitated by open dialogue and helpful rituals, family reorganisation and relationship-based realignment, and reinvesting in relationships and life goals, while maintaining bonds with lost loved ones, family processes facilitate both immediate and long-term adaptation to loss.

When faced with adversity, the risk for problems is increased due to the confluence of developmental and intergenerational pressures (McGoldrick et al., 2015; Walsh, 2016b). When current pressures trigger unpleasant memories and feelings from prior family events, particularly those with trauma and loss, distress is exacerbated (Walsh & McGoldrick, 2013). Family members may get overwhelmed, lose perspective, conflate present and past events, or block themselves off from painful connections and feelings. Expectations are influenced by earlier experiences with adversity: Catastrophic fears can increase the likelihood of dysfunction, but multigenerational models and tales of perseverance can motivate effective adaptation. Families, particularly immigrant and international families, are more resilient because they can preserve linkages between their history, present, and future and balance multigenerational continuity and change (Falicov, 2007, 2012).

**Figure 2: Theoretical Framework Diagram**



Source: Constructed by the researcher

## **2.8 Therapeutic Approaches to Family Interventions**

The present chapter has so far focused on a number of drawbacks or issues related to substance misuse, poor parenting, and dysfunctional households. We'll now change our focus to thinking about the theoretical underpinnings and tactical methods for avoiding or intervening to address these issues for individuals and their families.

It should be clear that an overall strategy that is comprehensive, systematic, and multi-dimensional is required given that substance misuse impacts families and individuals in every area of life (e.g., physical, mental, social, emotional, vocational, economic, and spiritual). All disciplines, whether they are broad (such as education, applied psychology, medicine, government, and religion) or more specialised (such as nutrition and fitness [Larson, 1992] or occupational therapy [Moyers, 1992]), have a wealth of knowledge and many pressing needs. After stating the requirement for all-encompassing solutions, let's think about strategies that are most suited for those working in positions like those of counsellors, psychologists, social workers, and different rehabilitation specialists.

### **i) Systems Theories in General**

Family systems theory, which is more narrowly oriented, is typically connected with the research of biologist Von Bertalanffy (1968). This theory's central tenet is that people are living systems made up of interconnected, interdependent subsystems (such as parents, siblings, and cousins). According to this interdependence concept, the total system is more important than the individual pieces (Nugent, 1994). Every living thing is thought of as a dynamic system that interacts with its surroundings and other living things. Instead of focusing on particular people or units, general systems theory pays emphasis to the transactional flow among all the people who make up a system. In this paradigm, maintaining homeostasis (balance) or a desired state inside the framework and by individuals—particularly those associated with “power” and “control”—is the major objective.

Every family has a different set of guiding ideas and duties that determine how it interacts. In this plan, not just individuals but also the entire families are to blame for every societal issue. Social units, like the family, bear a large portion of the blame for social issues (such as teen pregnancy, violence, and drug abuse), but they are also best positioned to intervene by providing support for those who act out, balancing power and control, and enhancing family functioning (Nugent, 1994).



## **ii) System Theory to Understand Family Resilience**

One of the specialists who helped establish the idea of family resilience, Walsh (1996), made a crucial point when he said that the family resilience framework is based on family systems theory, which combines ecological and developmental viewpoints. The viewpoint is used to examine how families behave in social and cultural settings and in circles that encompass multiple facets of family life. Resilience is seen as having a close relationship with broader individual elements, families, and social systems from an ecological or sociocultural perspective. Biological, psychological, social, and spiritual orientations can all lead to individual difficulties. Individuals may feel symptoms of discomfort due to biological factors such as extreme pain or neurological diseases. The impact of sociocultural factors, such as hardship and prejudice faced by communities and families who are at high risk for the onset of difficulties, can also cause problems. Family members may have symptoms as a result of crises-inducing incidents like sexual assault, sad loss, or the effects of major disasters. The family's stress will increase if they are unsuccessful in getting out of the bad situation. Resilience will be supported by families, peer groups, communities, schools, workplaces, and other social institutions. The holistic or multi-dimensional approach explores context variation, pinpoints crucial components in a crisis, and examines it from the resources, problems, and special perspective that the family has.

The condition of children and people who influence factors that contribute to and protect against the emergence of resilience must also be taken into account from this point of view. This is corroborated by Nugent's (1994) claim that social competency can be viewed through the lenses of family, peer groups, institutional settings (such as schools or workplaces), and larger social systems. The person will benefit from this social competency in dealing with any challenges or emergencies that may arise. It was acknowledged that in an environmental context, encouraging optimistic viewpoints is necessary. Living conditions must be rewarding and successful. Cynicism and despair can be brought on by events like violence or losing a job despite excellent performance. We must grasp the relationship between events

that take place within the family and those that affect the political, economic, social, and racial atmosphere in which people develop if we are to comprehend and promote psychosocial resilience and protective mechanisms. A developmental viewpoint can also be used to understand family resilience. The potential of individuals to adapt and manage with the obstacles they meet can be studied by occasionally seeing things in multiprocess, rather than simply addressing a set of characteristics or traits that already exist. Even tiny but complicated stimuli can alter an individual's past and future history; many types of psychosocial stress are not as straightforward as we might think (Nugent, 1994).

The most essential thing is that we can employ a variety of methods of coping to find challenges from the difficulties we confront so that our ability to deal with increasingly complicated situations throughout time isn't dictated by a single coping reaction. According to a study, risk variables do not always make it impossible for people to adapt or forecast if they will survive. The three elements that characterise the interaction of psychosocial and biological factors in determining adaptability to stressful situations were studied. The three aspects are: (1) susceptibility or propensity, (2) trigger or prospective stressors, and (3) protective factors that encourage resilience under stress and a person's capacity to tolerate the stress they face. To develop resilience and increase a person's likelihood of successfully overcoming a challenge to prevent family dysfunction or disruption, the process eventually involves bigger individual, family, and social environment components. The different developmental stages will balance stressful situations with defences that can boost resilience. At all stages of development, influences from family, peers, and stronger social bonds can also be observed. The family is viewed as a structure on which all members of the family and future generations will progress throughout their lifetimes according to the family life cycle orientation. Families can develop resilience and overcome challenges in a variety of ways over time. Accumulating stressors can overwhelm families. The impact of a crisis on a family varies greatly depending on when it occurs in an individual's or family's life cycle. The family experiences when responding to and facing challenges can be used as a guide.

### **iii) Systems Approaches Especially Applicable to Substance Abuse**

Methods that Freeman (1993) believes are suitable for treating substance dependence: These four focal factors or criteria - related to problems generally; substance addiction issues; treatment objectives; and major treatment procedures—are best used to characterise the communication, task-centred, structural, and problem-solving strategies. Freeman has also used these same standards to identify family therapy that primarily concentrates on intergenerational or strategic problems. There are commonalities among all theoretical uses of family systems, including the removal of substance addiction from the family system, the lowering of family stressors that might contribute to a relapse, and the improvement of the system's capacity for nurturing and assisting members.

Additionally, according to Freeman (1993), all family systems approaches emphasise typical therapeutic methods including assigning homework, participating in functional groups (such as a choral group), and objectifying the family system. Prior descriptions of problem-solving, structural, and communication methods were provided. However, it is important to clarify that the goal of task-centered groups is to teach, model, and train participants to increase their sense of competence and self-efficacy. One illustration would be to train parents to communicate with their teenagers by using "I" phrases and friendly body language. As task-centered groups, psychosocial educational training (such as discipline) and education for parents are increasingly done (McWhirter et al., 1993). Social support groups like AA and Al-Anon are examples of task-centered groups that are successful at establishing and sustaining change to reduce substance misuse and enhance family functioning (Williams & Swift, 1992). The person-centred planning method known as Circles of Support, which was first used in special education, appears to have a lot of potential for being applied to the mobilisation of natural supports to help focus individuals and families who are struggling with substance misuse (Perske, 1998; Snow, 1989).

#### **iv) Family Therapy Process**

The emphasis on interaction with and by the entire family system is a key component of family systems theory, which has developed from general systems theory. The concept of family systems theory is to intervene with everyone, even when many families are primarily plagued by a single person (Garrett, Landau, Shea, Stanton, Duncan, Baciewicz & Brinkman-Sull, 1998).

All members are impacted by a disturbed user, and all may add to the problem, and all of them are involved in finding a solution to the problem. Families can function both in closed and open family systems. According to Kaufman (1985), substance misuse or dependency can upset the homeostasis of a family just like any other stressor and frequently takes the place of other organising principles. The demands imposed on families to reorganise roles, regulations, and functions created by substance misuse are reflected in terms like “the alcoholic family,” “co-dependency,” and “enabling” (Steinglass, P., Bennett, L. A., Wolin, S. J., & Reiss, 1987). One of the most crucial intervention techniques used to combat drug misuse is family counselling. The assessment, goal-setting, development, implementation, and termination phases of the family counselling process are adapted from those of individual counselling. Family counselling’s evaluation phase serves as a window through which to observe how the family operates, manages stress, interacts with one another, solves problems, and engages with outside influences. As an illustration, triangle relationships may be seen in the assessment of family function, which is frequently done by seeing the family members in action (Bowen, 1978). In these relationships, two members of the family align themselves against a third family member.

Change is effected during the family counselling implementation phase. Effective communication techniques, such as active listening, are modelled and taught by counsellors. They participate by facilitating the resolution of conflicts and problem-solving while supporting all family members, especially those who are facing a challenge and require additional help. It is possible to redefine difficulties in

a way that is less offensive and more acceptable by redefining patterns of interaction and realities (Kaufman, 1985).

Counsellors must be managers or coordinators due to the intricacy of dealing with a slightly dysfunctional family group. Counsellors may need to act as mediators, allies, or advocates in situations when there is family strife, rage, or conflict. The termination phase concludes family counselling while laying the groundwork for ongoing goal-achievement. Because family systems are dynamic, it is important to teach members how to see the growing issues that arise for those in the family of various ages as well as how the family life cycle necessitates several transitions as time goes on (Carter & McGoldrick, 1980).

#### **v) Stages in Family Counselling**

At different phases of recovery and healing, family requirements change. All authors who write on family therapy agree that there is a continuity of stages or care from the start of treatment to its conclusion, albeit different theorists offer slightly different perspectives on the layers in stage composition.

For instance, numerous family professionals have proposed the following related processes as four foreseeable levels in family counselling (Perez, 1979): 1) Initial Stage: Establishing a connection and evaluating family issues. Developing emotional awareness and acceptance of dysfunctional family patterns is the goal of the middle stage. 3) Final Stage: Assisting the family in learning how to alter their practises. 4) Termination: Assisting the family to stop going to therapy and continue receiving other forms of care. When substance misuse is a serious issue, some theories have proposed phases or stages for family coping and intervention in families that are partly linked.

According to Ackerman (1983), there are four stages to the family's reaction to alcoholism: reactive, active, alternate, and family unity. Ackerman warns that not all families are going to progress through the phases and claims that many stay in the first phase, failing to move past family denial and poor coping mechanisms, as well

as deeper into social disengagement. Sobriety attainment, sobriety adjustment, and long-term maintenance of sobriety are examples of three stages of treatment.

Exasperation, effort, and empowerment are the three stages of the healing process, according to Schlesinger and Horberg (1988). People experience emotional overload and a loss of control in the early stages of “exasperation,” and their families are a mess of confusion, guilt, and helplessness. Families start to realise there is a chance for improvement in their lives and sense relief from chaos in the middle zone of “effort.” Families that finish the last level of “empowerment” start to feel competent or self-sufficient and hope that their aspirations might come true. For families who move through Region Three, feelings of safety, respect, pride, and trust—all of which are seriously challenged in Region One—increase significantly.

Another model for families dealing with alcoholism (Usher, 1991) divides recovery into four successive stages: (1) “treatment initiation,” where the counsellor conducts clinical assessments and leads the family in treatment; (2) “learning,” where the family learns new coping mechanisms to use once alcohol has been eliminated from the family system; (3) “reorganisation,” where the therapist assesses the family’s capacity to maintain abstinence and aids in the healing process; and (4) “closure.”

When there is trauma from substance misuse, all of these models of family counselling hold the same view that rehabilitation is a journey rather than a one-time thing. Additionally, they all accept the notion that the majority of family systems possess the capacity to bounce back and acknowledge their status as sound units. These models all include a warning that the capacity to alter systems positively is closely related to the degree of change readiness.

Lewis (1992) developed yet another family counselling paradigm that is intended to bring people together. Three steps are emphasised by this so-called “overarching” approach: breaking up existing patterns, accepting the facts of change, and intensifying and maintaining change. At the beginning of therapy, the counsellor helps the family members break the negative habits that had previously defined their

dysfunctional family system by providing them with the options of confrontation or disengagement. The goal of confrontation is to get the substance abuser to acknowledge that they have a problem that needs to be treated. When family members need to start the transformation process without the help of the substance abuser, disengagement happens. The disengagement process, according to Schlesinger and Horberg (1988), can break up rigid patterns of contact, bring consistency by establishing boundaries, and assist family members in letting go of the codependency trait of accepting responsibility for others' behaviours. Ackerman (1983) contends that disengagement can aid family members in transitioning from a "reactive" (passive mode) to an "active" (assertive) style in a manner that is somewhat similar to 8.

Secondly, according to Lewis (1992), family members go through a significant adjustment in the second stage that has to do with resolving issues and interacting with one another without the use of drugs or alcohol. Although it may not seem like a big deal, Lewis thinks it is a crisis since families have been going about their daily affairs based on routines of transactions involving alcohol or drug abuse and hasn't developed the necessary problem-solving or conflict-resolution abilities. Many families react to the strain of a crisis by divorcing or going their separate ways. Others attempt to restore the twisted equilibrium of drug misuse that they have known for so long (Usher, Jay & Glass, 1982). Counsellors can help families understand that a different crisis may replace the flight from the turmoil of substance misuse, requiring a different set of roles and skills (Lewis, 1992). This understanding can be very beneficial to families. Focusing on immediate objectives like maintaining harmony within the family unit, minimising disagreements, and empowering each family member to take care of their own needs can help the family weather the current crisis. Additionally, to give the family time to adjust, worries regarding a potential substance relapse should be handled within the framework of minimal structural adjustments (Ackerman, 1983).

The third and final stage of Lewis's general model (1992) focuses on preserving and deepening change. Realistic expectations, ongoing development of

assertiveness, negotiating, and problem-solving abilities, as well as empowerment, are prioritised. The counsellor's duties throughout the phase of strengthening and maintaining change include acting as a great parent figure, serving as a barometer of reality, educating clients, and setting an example of positive behaviour (Ackerman, 1983).

#### **vi) Six Main Types of Family Counselling**

Family counselling presents several points of view, just like every other counselling modality. These opinions are expressed in the books and lectures of well-known therapists and educators. One of the most well-known theories is psychodynamic family therapy, followed by experiential/humanistic counselling, Bowenian therapy, structural therapy, communication theory, and behavioural intervention. Each of these viewpoints is predicated on the notion that disturbed people have an impact on and are influenced by their families. Each method looks at how a person develops in a social setting (Lewis, 1992).

Through a number of family techniques, general systems theory-related family dynamics and development can be used to treat substance dependence. Regardless of their theoretical approach, family therapists address present problematic family dynamics, investigate relations and tensions within the family, and take into account how these dynamics and conflicts affect both the entire family and the individuals inside it. Family therapists typically participate actively in sessions and frequently serve as organisers, educators, and mentors as families are reorganised to have healthier patterns of interaction (Nugent, 1994).

Goldenberg and Goldenberg (1985) offered one extremely helpful and commonly used classification of family therapy, outlining six different forms based on eight criteria:

1. Major time frame
2. Role of unconscious processes
3. Insight vs. Action
4. Role of the therapist



5. Unit of study
6. Major theoretical underpinnings

### **vii) Psychodynamic Family Therapy**

This method, which is founded on psychoanalytic theory, emphasises how individual disease and deviance affect the family structure. It suggests that understanding is crucial for change and sees the family as a collection of interconnected people. One of the early proponents of family therapy, Nathan Ackerman (1981), suggests that therapists form a close relationship with other family members and use the strength of that bond, as well as their knowledge, to overcome defences and turn dormant disputes into open, interpersonal interactions. In this model, the therapist serves as a kind authority figure or “great parent figure.”

### **viii) Experiential/Humanistic Therapy**

Although Virginia Satir’s career dates back to 1967, communication theorists may be more familiar with her work as a pioneer of experiential/humanist therapy. Satir’s method of family counselling focuses on the regular interactions between particular families. Satir has discovered a number of dysfunctional communication patterns, including placatory, blamer, and super-reasonable person. Through therapy, families are urged to break free of dysfunctional habits and adopt more consistent, adaptable, and open communication (Goldenberg and Goldenberg, 1985).

### **ix) Bowenian Family Therapy**

“Differentiation of self” is the cornerstone concept of the family therapy system developed by Murray Bowen. This concept “defines people according to the degree of fusion or differentiation between emotional and intellectual functioning. This characteristic is so universal that it can be used as a way of categorizing all people on a single continuum” (Bowen, 1978).

People at the lowest end of this continuum are less flexible, less adaptable, and less emotionally dependent. At the other extreme are individuals and families who are more flexible, more adaptable, and more independent of the emotionality of

those around them. Another central concept of Bowen (1978) is the “multigenerational” transmission of problems, such as marital conflict, dysfunction in one spouse, or projecting blame onto children. One other key notion is that of “triangulation,” where two parts of a family form an adversarial alliance to combat another part (e.g., one parent and children versus the other parent).

Counsellors using Bowenian therapy focus on increasing family balance by recognizing multigenerational patterns of behaviour (e.g., punishing others through silence or glares), modifying the central family triangle, and encouraging the process of differentiation. The anticipated outcomes of this therapeutic process are increased individuality and identity of each family member and, therefore, increased health of the whole family (Bowen, 1978).

#### **x) Structural Family Therapy**

Therapists using the system-oriented strategy must engage the family in interactive activities, where they can objectively observe and assess “enduring interactional patterns that serve to arrange or organize a family’s component subunits into somewhat constant relationships” (Lewis, 1992).

The process of change begins as the counsellor gains information to understand family dynamics and family structure. Subsequently, the counsellor gradually confronts the family’s perceived reality and shifts focus from the individual symptom bearer (e.g., substance abuser) to the whole family system. The main outcome goal of this therapy is to “change the structure of the family system, making it more functional in its environmental context” (Lewis, 1992).

#### **xi) The Communication Model**

Much of the pioneering work on the communication model, which also was created from a systems perspective, was begun in the 1950s by Gregory Bateson and an interdisciplinary team that was to become the Mental Research Institute (Lewis, 1992).

Bateson's work was instrumental in shifting the focus of family therapy from the single individual to the exchange of information and the process of evolving relationships between and among family members. It was also Bateson who stressed the limitations of linear thinking regarding living systems.

He called instead for an epistemological shift to new units of analysis, to a focus on the ongoing process, and to the use of a new descriptive language that emphasizes relationships, feedback information, and circularity (Goldenberg & Goldenberg, 1985). The strategic treatment of Haley (1976) and Madanes (1981), which focused on active strategies for modifying repetitious communication patterns amongst family members and for negotiating solutions for solvable problems, is probably the best example of the use of the communication paradigm. The therapist gives instructions for families to adhere to throughout treatment after coming to an understanding of one or more manageable difficulties. A paradoxical command is one in which a therapist instructs a family member to maintain a behaviour (such as cynicism) that would otherwise be the subject of therapy (Lewis, 1992).

### **xii) Behavioral Family Therapy**

Liberman (1981) and other behavioural therapists see the family as a "system of interlocking, reciprocal behaviour". When employing the behavioural family therapy technique, counsellors look for strategies to promote new, constructive habits that can take the place of negative ones. As a social assistance, drinking water, coffee, or tea might take the place of alcoholic beverages. Similarly, using a worry stone instead of cigarettes could become more popular.

Counsellors utilising this approach play a crucial role in modelling good behaviour so that learners can closely watch positive behaviour. The focus of Liberman (1981) and other family counsellors who employ social learning approaches is on certain quantifiable behaviours as well as the environmental factors that contribute to and sustain them. By changing the conventional methods of reinforcement (such as talking instead of yelling) with the models offered by the social unit (such as time out instead of punishing silences), concrete goals are

produced. Behaviourists, who think that the explanation, demonstrations, and guidance/supervision of learners contribute to greater competence and confidence, place a high value on teaching and training by a therapeutic leader. High attention skills, such as eye contact, stress management strategies, such as time management or negotiating, and self-control ways to change behaviour, such as relaxation techniques and refraining, are a few examples of this type of training.

### **5. Synthesizing Differing Family Therapies**

A theoretical orientation to family therapy emphasises either one person or the family as a whole. Multiple approaches to family therapy provide an A to Z continuum. Position Z therapists exclusively concentrate on the family system as a framework for both pathology and change, while position A therapists, like Ackerman (1983, 1987), concentrate on the psychodynamics of the person. Theoretically, inclined position Z therapists are considerably more likely to hypothesise that conventional mental health issues are social and interpersonal manifestations of dysfunctional family functioning.

In this technique, the therapist facilitates reality checks, imparts knowledge, and serves as a role model for skills and situationally appropriate behaviours. Freeman (1993), who claims that all family system methods have five general implications regarding family treatment, provides some helpful integration of a few different main therapy techniques. One overarching implication is that individual, couple, family, and group sessions can benefit from the application of a strong combination of modalities.

Another conclusion is that while sometimes it may be desirable to support family members as they separate, come to closure, and adjust to new familial ties, on other occasions, it may be best to do the opposite (Janzen & Harris, 1986).

An additional investment in preventive and pre-treatment resources is a third implication that encompasses all theoretical and therapeutic approaches. This makes sense in particular when the problematic member of the family is yet to begin engaging in substance misuse or when abuse is already severe and when the

offspring are young. The fourth implication is that systems theory aids in the prediction of risk potential during times of normal family developmental changes, such as when teenagers must create distinctive identities and forge close relationships (Boyd-Franklin, 1989).

A fifth implication is that these methods frequently may require particular adjustments. These options include families with numerous addicts, families from ethnic and minority groups, families that blend, couples, single-parent families, and families with the same gender. With a few notable exceptions, very few of these strategies have been used to address racial difficulties in families, which is a shortcoming that needs to be addressed (Boyd-Franklin, 1989).

## **6. Obstacles to Coping with Substance Abuse**

There are obstacles to practically every difficult life goal. Managing substance abuse is undoubtedly difficult for both individuals and family systems. The benefit of having a firm grasp on actual issues and coping mechanisms is that it creates the conditions for major personal development. The main obstacle to coping, significant others' co-dependency, will be the subject of most of this chapter's attention. Irrational worries and other challenges will be briefly discussed. Unsolved disputes between people closed-off, linear strategies high anxiety or anger guilt and shame inadequate time management and organisation self-efficacy is low. Differentiated cultures have inadequate social skills several diagnoses of social support are insufficient (Janzen & Harris, 1986).

### **i) Co-dependence**

The barrier of codependency is related to the idea of family interdependence and the belief that a problem with one member of the family can affect the entire family system (Nugent, 1994). Families lose their equilibrium (homeostasis) when substance use progresses to levels of abuse and addiction, which increases pressure on family members to take on obligations for the abusive or addicted family members. Members of the family are entangled and true communication is scarce

when family boundaries are murky. Members frequently indulge in fictitious closeness instead.

There is a strong undertow that might jeopardise healthy family members and cause them to play different compensatory roles to regain balance. One such role is that of an “enabler” (Williams & Swift, 1992), which typically takes place when a partner or spouse conceals the abuse and takes on many of the user’s tasks. The enabler frequently sees themselves as a martyr and is viewed as such by others (Hogg & Frank, 1992; Schaef, 1986).

Children in families that are severely damaged by alcohol or drug abuse take on complementary responsibilities to protect themselves from emotional stress as well as to protect their families while preserving concealment, denial, and “face-saving.” One child might play the role of the “hero,” who succeeds and saves the family; another might bring humour as the household clown or mascot; another may assume the responsible role of “enabler”; one might turn into an unnoticed “lost child,” and others might play out family issues by acting as the “scapegoat” (Ackerman, 1987).

According to Wegscheider-Cruse (1985), co-dependence is an additional component of a relationship that restricts self-expression and self-growth and is very similar to a person’s addiction to alcohol or drugs. Members of a codependent household cannot articulate their own needs, interests, and feelings because they have not grown into independent adults (Nugent, 1994). Co-dependency, according to Wegscheider-Cruse (1985), is an excessive reliance on one person that eventually develops into a dysfunctional relationship and has an effect on all other intimate relationships.

According to Subby (1987), co-dependency is brought on by a lifetime of being subjected to restrictive, closed-family rules that hinder honest conversation about and open expression of one’s concerns. According to Hawkins (1998), co-dependency develops when people suppress their sense of self or fail to get their wants and needs addressed.

According to Cermak (1986), codependence is a maladaptive response to free-floating anxiety or shame that is reduced by excessive self-control and control of others (Subby, 1987). Since codependent people typically grow up in shame-based familial contexts and have little sense of self or identity, shame is a major contributing factor to codependency. An “enabler” is a person or people who facilitate substance misuse and family disarray in a codependent family structure.

In his book *The Enabler* from 1986, Cermak provides the following definition: “...the person who supports someone capable of standing on his or her own is an enabler”. According to Miller, being an enabler is an acquired skill, and those who are enablers actively pursue virtue and righteousness. Miller lists sacrifice, tolerance, acceptance, hard effort, capability, courage, toughness, forgiveness, knowledge, and love among the many attributes of the enabler. According to a number of publications (Beattie, 1987; Cermak, 1986; Freeman, 1993; Hogg & Frank, 1992; Mellody, Miller & Miller, 1989; Subby, 1987; Wegscheider-Cruse, 1985), a number of characteristic actions are said to be typical of co-dependency.

Examples of typical co-dependent tendencies are: Martyrdom is sacrificing one’s needs in order to satisfy those of others. Fusion is losing one’s sense of self in an intimate relationship. Intrusion is controlling intimates’ behaviour through excessive concern, guilt, or manipulation. Perfection is having unattainable standards for oneself and others. Addiction is using compulsive behaviours to control one’s emotions. Co-dependence has been the subject of entire books. Two such enlightening publications have been written by co-dependent and professional Beattie (1987).

Another book by Mellody, et al., (1989), titled *Facing Co-dependency*, largely highlights the principal author’s history as a co-dependent. According to Subby (1987), repressive laws that fail to support families and encourage dysfunction include: “Don’t feel or talk about feeling,” “Don’t identify, talk about, or solve problems,” “Don’t be who you are good, right, strong, and perfect,” “Don’t be selfish take care of others and neglect yourself,” “Don’t have fun,” “Don’t trust other people or yourself,” “Don’t be vulnerable,” “Don’t be direct,” “Don’t get close to other

people,” and “Don’t grow, change, or in any way rock this family’s boat” (Beattie, 1987). Beattie writes in *Codependent No More* (1987) and *Beyond Codependency* (1989) that she experienced coercive restrictions both explicitly and implicitly in her own life. She states that “co-dependency is about the ways we have been affected by other people and our pasts, which can result in damaging other messages like “I’m not lovable,” “I don’t deserve good things,” and “I’ll never succeed” (Cermak, 1986; Beattie, 1987).

According to authors like (Cermak, 1986; Beattie, 1987), the trauma associated with substance addiction that many youngsters experience persists and has an impact on them as adults. Codependence, according to Beattie and Melody, is a sickness in and of itself, and according to Cermak (1986) it is a subtype of post-traumatic stress disorder. Cermak says that “the symptoms of stress disorder in co-dependency are similar to the symptoms of stress disorder in war veterans.”

Beattie (1987) affirmed that “codependent feelings and behaviours of fear, anxiety, shame, an overwhelming need for control, neglecting ourselves, and focusing on others may suddenly emerge when something in our current environment reminds us of something noxious.”

According to Cermak (1986), the two main signs of codependence as a stress condition are “psychic numbing,” in which people try to live by numbing their feelings, and “hypervigilance,” in which people strive to feel comfortable by constantly watching their surroundings. According to Melody, Miller, and Miller (1989), codependents struggle with the following five fundamental symptoms: 1) Experiencing appropriate levels of self-esteem; 2) Setting functional boundaries; 3) Owning and expressing their reality; 4) Taking care of their own adult needs and wants; and 5) Experiencing and expressing their reality moderately (p.4). For a thorough explanation, readers are directed to their book, *Facing Codependence*. Although codependence is thought to be the main obstacle to stopping substance usage and recovering from it, it is a disorder that may be managed. Nace (1987) offers two beneficial treatment recommendations.



They first suggest that couples and families should work through their issues and attitudes in order to achieve enough functional independence or separateness to take the place of dysfunctional roles including excessive control, management, or manipulation. Second, according to Nace (1987), the success of an intervention depends on the family member's ability to control their intense negative feelings such as anger and resentment, as well as their propensity to place the blame on the recovering substance abuser.

## **7. Other Obstacles to Prevention and Recovery**

The brief statements that follow discuss additional obstacles that need to be taken into account to stop substance usage and to direct rehabilitation efforts.

### **i) Irrational Fears**

People who abuse substances frequently experience powerful, distressing feelings like panic attacks, nervousness, humiliation, guilt, and blame. They also frequently experience excessive anxiety. Irrational fears can occasionally develop a life of their own and do more harm to people's lives (Beattie, 1987). The most effective treatment for decreasing or getting rid of unreasonable concerns appears to be cognitive-behavioural therapy.

### **ii) Closed, Linear Intervention Approaches**

Families of substance abusers will gain the most from several complementary interventions because they have numerous needs (Stocker, 1998). The illness model of alcohol and drug addiction is particularly restricted in that it has a limited scope, adheres to stringent guidelines, and asserts in an authoritarian manner that the Twelve-Step approach is "the only way" to recovery. The Transtheoretical Model for Behaviour Change, which urges counsellors to deliver the proper treatment procedures (process) at the appropriate time (stage), is one example of the blended approach that experts are increasingly advocating (Lam et al., 1996).

### **iii) Shame and Guilt**

By concentrating on the relationships between guilt and shame and the distinction between them, Fossum and Mason (1986), according to Nugent (1994), made a significant addition to the rehabilitation of alcoholics and co-dependents. Guilt entails acknowledging a wrong or harmful behaviour and changing it, which boosts self-esteem. Shame, on the other hand, is much more harmful because it stems from the belief that one is flawed, undeserving, or insufficient (Hawkins, 1998). In alcoholic households, shame is fostered and reinforced, causing kids to take these emotions into their adult relationships. Intimate or close interpersonal interactions are particularly difficult for such adults to form (Ackerman, 1983; Black, 1981; Fossum & Mason, 1986).

### **iv) Low Self-Efficacy**

Shame and other traumatic effects of substance addiction frequently have long-lasting detrimental effects on one's self-worth and ability to function. When people feel unworthy (Fossum & Mason, 1986) or insufficient and lack the confidence to perform successfully (Cermalc, 1986), their ability to achieve is compromised. Children raised in households that emphasise unhealthy connections, such as "I'm OK, you're not OK" and the advice to "don't talk, don't trust, and don't feel" (Black, 1981), are more likely to carry their uncertainty and ambivalence into adulthood as well as experience sporadic post-traumatic stress (Beattie, 1987).

### **v) Weak Social Support**

The majority of external affirmation of one's value comes from the encouragement and support of close friends and family members. However, the damage that substance misuse has on families and kids frequently results in a dysfunctional family that is apart from one another and uncommunicative with the outside world. In general, support for emotional, mental, leisure, and everyday living activities is denied or reduced when disempowerment prevails (Beattie, 1989; Rubin, 1993; Bennett, Wolin, & Reiss, 1987; Black, 1981).

#### **vi) Inadequate Social Skills**

Social skills that significantly increase social support include listening, giving feedback, acting appropriately, self-disclosing, identification, and self-awareness, expressing feelings both vocally and nonverbally, assertiveness, problem-solving, and conflict management negotiation (Johnson, 1996). People with excellent social skills typically have a robust social support network, while people with inferior social skills typically have weaker social support and frequently have relationships that are conflict-ridden. Training in interpersonal skills is crucial in the care of substance abusers because it gives them a way to deal with risky situations and gain more social support. Helping those who are struggling with substance misuse can be very successful with assertiveness training, which includes teaching rejection skills (Goldstein, Reagles & Amann, 1990).

#### **vii) Unresolved Interpersonal Conflicts**

People are frequently hindered by their incompetence or unwillingness to resolve problems. According to Beattie (1987), “Difficulty managing sentiments, particularly anger, can impair our negotiation skills. The question can change from “How can I fix this?” to “What can I do to punish you for making me mad?” As a result, some people are propelled into conflicts with others by their embarrassing gaffes and poor social abilities. Particularly, it is advised to use negotiation as a tactic to lessen or settle disputes (Beattie, 1987; Johnson, 1996).

#### **viii) High Stress and Anger**

Stress and rage in moderation can be stimulating and advantageous, but excessive amounts can be harmful to people and family units. Relaxation training (Jacobsen, 1968), illustrating constructive interaction abilities, such as eye contact, stance, and substance-refusal preparedness (Goldstein, Reagles & Amann, 1990), systematic desensitisation (Lewis, 1992), and training in social skills (Johnson, 1996), are a few strategies to help people manage their stress and rage.

### **ix) Non-mainstream Culture**

Ethnic cultures could normalise drug use and encourage people to resist help. Building trust requires being aware of both verbal and nonverbal communication patterns and spending time to establish a relaxed environment (McRoy, Sharkey & Garcia, 1985). Due to unsatisfactory prior interactions with experts, many families may exhibit severe cultural paranoia (Boyd-Franklin, 1989). Choosing and educating counsellors who are contextually aware of the needs and goals of minorities is necessary (Brown & Srebalus, 1996, pp. 163–186).

### **x) Dual Diagnosis**

This phrase typically describes the co-existence of drug misuse and mental illnesses. Between 30% and 70% of people with substance abuse problems also have at least one other mental disease, such as depression or personality disorder, according to a 1990 assessment of the research literature by Penick et al., People who struggle with both substance misuse and significant physical limitations suffer from a dual diagnosis. Two or more diagnosis problems provide a larger risk to people and families and make coping more difficult.

## **8. Challenges in Research about Family Resilience**

An idea or construct is essentially tested, verified, or strengthened in research carried out by professionals or researchers who have a keen interest in family studies. The most recent discoveries of study on an idea or structure may help to develop and provide additional clarity for its definition or limitations. According to recent studies on resilience, the focus is moving away from individual resilience and towards family resilience (Walsh, 1996). Despite the background of family dysfunction during this time, resilience is frequently predicted to emerge primarily at the individual level. However, when family resilience is considered systemically, it can also be linked to efforts to build both individuals and families. Family-related characteristics in the framework of resilience include not only aspects like affection, tenderness, and emotional support within the family but also aspects like family challenges or traumas (Patterson, 2002).

Even though a child's home is frequently violent, some aspects of the family may endure. As a result, despite the ongoing bad luck, a youngster may continue to be strong. According to Walsh (1996), ties with other family members, including older siblings, grandparents, and other relatives, can fill in for the absence of a strong home environment. Walsh's viewpoint is consistent with Werner's research findings from 1985.

According to Lietz (in Becvar, 2013), Werner and Smith (2001), who researched high-risk youth for 40 years, had a significant influence on early resilience research. 698 infants born on Kauai Island over a year were the subjects of a longitudinal study by the researchers. High-risk samples made up one-third of the total. These children: 1) go through prenatal stress; 2) are born into poverty; and 3) are brought up in a tumultuous environment, with parents who have addictions or mental health issues. Then, every 10 years, samples from participants who are adolescents are evaluated. This study identified several new protective variables that enabled many of these kids to effectively navigate difficulties and eventually mature into well-functioning adults, such as sustaining a relationship with one or more caring adults. The most significant aspect of this study is how it encourages us to look at the way risk factors and guardians interact to improve functioning. These studies lead us to the conclusion that personal characteristics and protective factors in a familial and societal setting have a dual role in determining an individual's ability to overcome challenges. A growing body of fresh studies on family resilience is emerging. The researchers clearly outline the fabrication steps of some of the instruments used to support their work. Additionally, this family resilience study is seen in a variety of approaches and contexts. The setting, methods, and instruments of some of the research projects covered in this paper are taken into consideration.

It is clear from the paper and journal overview of earlier studies on family resilience that this field of study is applicable in a variety of settings. Research on resilience has been done in multiethnic nations, developed nations, and developing nations. The approach employed in the study is likewise diverse; while some researchers exclusively use one, the mixed method was used for the vast majority of

their work. Similar to this, the research tools are diverse and exhibit rapid progress. To measure the circumstances to be measured, some instruments have been designed with good validity and reliability. Others also employ qualitative data-gathering strategies, which are not restricted to comprehensive interviews but also include focus group discussions (FGD) activities. The focus of the research on family resilience was determined by the goals of the study. These studies are made more intriguing by the fact that the issues or challenges faced by the participants depend on a variety of stressors, including stress in particular occupations (such as nursing and caregiving), married individuals, and inmates. The majority of the research is done on families where at least one member suffers from severe mental illness, congenital deformities, or degenerative pain. The findings reveal that a variety of variables are linked to or represent recent discoveries that can foster family resilience.

Additionally, it was discovered that providing shelter is the most commonly occurring family role in high-risk contexts, according to a compilation of studies on family resilience. In the populations selected with high-risk lives, the researchers concentrated on examining resilience, although safeguards could not be found. According to the study (Borge et al., 2016), protection factors help families function better while also making risks or problems worse because certain families suffer compounded dangers. Another study was carried out by Anagnostaki and colleagues, who used a cross-sectional design to examine how individual differences (such as self-efficacy and sense of control) and family factors (such as parental school engagement, education, and parental support) affect variations in individual and group achievement. The study compared the academic performance of immigrant adolescents from Albania who had recently transferred to high school with that of their primarily Greek teenage friends. Regardless of the respondents' immigration status, the findings show a correlation between personal and familial resources and academic achievement. Low social standing and immigrant status are still recognised as distinct risk factors for kids who perform poorly in academics (Borge et al., 2016). Family resilience characteristics have been the focus of numerous studies. These

variables were derived via component analyses of the sociocultural setting, theoretical framework, qualities, antecedents (stressor and facilitator), and outcomes.

The objective is to assess the state of the family resilience concept for upcoming research requirements. The keyword “family resilience” was used to gather the data from six electronic databases. Following data collection, 17 quantitative studies, 17 qualitative studies, and 4 mixed-method studies were chosen as the data sources. The analysis findings revealed six dimensions of family resilience: (1) shared beliefs; (2) connectedness; (3) a positive way of life; (4) total empowerment, including the capacity to identify and offer support to others; (5) open communication pattern; and (6) the capacity to work together to solve problems. Meanwhile, family resilience is found to be influenced by three antecedent characteristics, including: (1) acceptance of the disequilibrium environment; (2) spirituality/belief/religiosity system; and (3) family strength while facing significant issues. The effects of family resilience are also examined, and these include: (1) accepting the situation; (2) altering one’s perspective of life; (3) improving the quality of relationships; (4) enhancing the traits that foster resilience; and (5) enhancing the results of efforts to maintain health. It is interesting to note from Oh and Chang’s research that the current study attempts to expound thoroughly on the data acquired. While information on the effects of family resilience is used in qualitative research, previous dimensions and determinants are acquired from studies utilising quantitative methodologies. Both approaches will yield noteworthy findings that will aid future researchers in conducting a more thorough study of family resilience.

The family is the fundamental societal unit and is tasked with preserving equilibrium or social order as well as fostering its members’ long-term growth and development (Freeman, 1993). The family is a cohesive or bound group of people who perform complementary roles (such as parent, child, or friend) to carry out important responsibilities like ensuring financial safety and security, sharing a common cultural background, sharing employment, creating identity management,

transmitting societal values, educating children to grow into responsible and independent adults, and satisfying intimacy or affection needs.

It is difficult to identify an average family system in America due to the complexity and quick change of the culture. Even marriage has emerged as a viable option for starting and maintaining families. The majority of family structures, however, fall into one of three categories: single-parent families, typically led by divorced women; dual-career families, where nearly 100% of men and 75% of women work; and remarried/blended families, formed when two previously married individuals with children get married again (Hayes & Hayes, 1991). All three types of families are common and functional, with heads of households and members playing complementary responsibilities.

Families are fundamental to the cause of addiction and recovery, according to the literature discussed in this essay because substance abuse hurts and occurs in families. A more thorough participation of families in future research is something that should be taken into consideration, according to the evaluation of the present state of the literature. The research gaps are as follows:

- 1) Most studies measure the frequency, prevalence, and consequences of substance abuse in terms of a single substance user; it is simply not known to what extent a family member's abuse of alcohol and other drugs hurts the family.
- 2) Substance addiction about the family's functioning traits: The vast majority of philosophical positions do not enlighten areas of research that represent the variety and dynamic nature of families. Families are frequently examined from a snapshot of the family at a given point in time in addiction research and therapy. In other words, vibrant families with a rich history are frequently reduced to a single "treatment episode" or are only considered in terms of how they affect the drug user. What's lacking is how substance misuse affects how dynamic families interact with one another.
- 3) The progression of family substance abuse and recovery: Family substance use is not a static phenomenon, but is more likely to follow a progression



from experiment to misuse to abuse or dependence. There is little literature on the long-term effects of substance misuse on the family.

- 4) Using families as a unit of analysis in research on substance abuse: The main premise of this essay is that family is an important factor to take into account while dealing with the majority of cases of substance abuse. As a result, rather than focusing solely on individuals inside families, it's important to find strategies to consider how addictions affect the entire family. The majority of studies have not taken into account the substance-affected client as a member of the family that includes these people and the various family roles that they may fulfil, even though numerous studies involve evaluations of partners, children, parents, and in some instances other family members.
- 5) Using families as resources to create anti-drug and alcohol addiction programmes. Parents serve as key role models for their children's substance usage, as is well known. Children who are raised by parents who use drugs and alcohol frequently do the same. The non-using partner frequently develops a substance use disorder or codependency in relationships when one partner has a substance abuse issue to keep the pair together. Although there is little literature on this topic, these "sources of influence" could be the key to creating successful prevention and intervention programmes.
- 6) Family risk and protective factors related to substance abuse: Family-related risk and protective factors as moderators or mediators of problematic behaviour have been primarily examined concerning child and adolescent substance abuse and little literature is found that extends this view to families.
- 7) Although the family has been viewed as an important factor in the rehabilitation process, there is limited research on the relationship between the family and the quality of life of substance abusers.

## **2.9 Drug Policies in India**

The Narcotic Drugs and Psychotropic Substances Act (1985) and the Prevention of Illicit Trafficking in Narcotic Drugs and Psychotropic Substances Act (1988) are India's two main anti-drug legislation.

## **1. Legal Background**

### **Narcotic Drugs and Psychotropic Substances Act**

On August 23, 1985, the Lok Sabha first heard the introduction of the Narcotic Drugs and Psychotropic Substances Act of 1985. On September 16, 1985, the President gave his assent after it had been approved by both Houses of Parliament. The Narcotic Drugs and Psychotropic Substances Act, 1985 (often abbreviated as NDPS Act), went into effect on November 14th. Any production, manufacture, cultivation, possession, sale, purchase, transportation, storage, and/or consumption of narcotic drugs or psychotropic substances are prohibited by the NDPS Act (Central Bureau of Narcotics, 2017).

With effect from March 1986, the Narcotics Control Bureau was established in accordance with one of the Act's requirements. The Act is intended to fulfil India's duties under the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, the Convention on Psychotropic Substances, and the Single Convention on Narcotic Drugs. Three times, in 1988, 2001, and the most recent one in 2014 (NDPS Amendment Act, 2014), the Act has been revised.

The 2014 Amendment acknowledges the necessity for pain management as a crucial duty of the government. It produces a group of drugs known as Essential Narcotic Drugs (ENDs). In order for the entire nation to now have a standard law covering these medications that are needed for pain management, the authority for legislation on ENDs has been transferred from the state governments to the central governments (Central Bureau of Narcotics, 2017).

In May 2015, the Indian government announced the NDPS guidelines, which would be applied to all states and union territories. Additionally, it contains 6 drugs: hydrocodone, codeine, oxycodone, methadone, and morphine. According to these regulations, the state drug controller is the only body that may provide the go-ahead for Recognised Medical Institutions (RMI) to stock and dispense ENDs without the need for any additional licencing. The RMIs are required to guarantee correct

paperwork and to provide the state's drug controller with annual consumption figures (Hindustan Times, 2016).

The Act covers the entirety of India, as well as all Indian nationals living abroad and everyone on ships and aeroplanes with Indian registrations. Dr. Dharamvira Gandhi, a member of parliament, declared a plan to change the NDPS Act through a Private Member's Bill in November 2016. The Dr. Gandhi bill would make opium and marijuana lawful (Narcotics Control Bureau, 2009).

## **2. Prevention of Illicit Trafficking in Narcotic Drugs and Psychotropic Substances Act**

The Indian Parliament passed the Prevention of Illicit Trafficking in Narcotic Drugs and Psychotropic Substances Act in 1988 as a drug control measure. It was created to make it possible for the Narcotic Drugs and Psychotropic Substances Act of 1985 to be fully implemented and enforced.

### **Narcotics Control Bureau**

The main law enforcement and intelligence organisation in India charged with preventing drug usage and trafficking is called the Narcotics Control Bureau (NCB). The Prevention of Illicit Trafficking in Narcotic Drugs and Psychotropic Substances Act (1988) was passed on March 17, 1986, to enable the full execution of the Narcotic Drugs and Psychotropic Substances Act (1985) and combat its violation (The Gazette of India, 2018).

## **3. Punishment**

Anyone who violates the NDPS Act shall be punished according to the amount of the prohibited substance they use. If the offence includes a minor amount (less than 1 kg), the punishment may include both severe jail time for a term that may not exceed 6 months and a fine that may not exceed 10,000; When a violation involves a quantity greater than small quantity but less than the commercial quantity, the punishment may include severe jail time for a term that may reach 10 years and a fine that may reach one lakh rupees; when a violation involves a commercial

quantity, the punishment may include rigorous imprisonment for a term that must not be less than 10 years but may reach 20 years and must also be subject to a fine that must not be less than one lakh rupees but may reach two lakh rupees (The Gazette of India, 2018).

#### **4. Controlled substances**

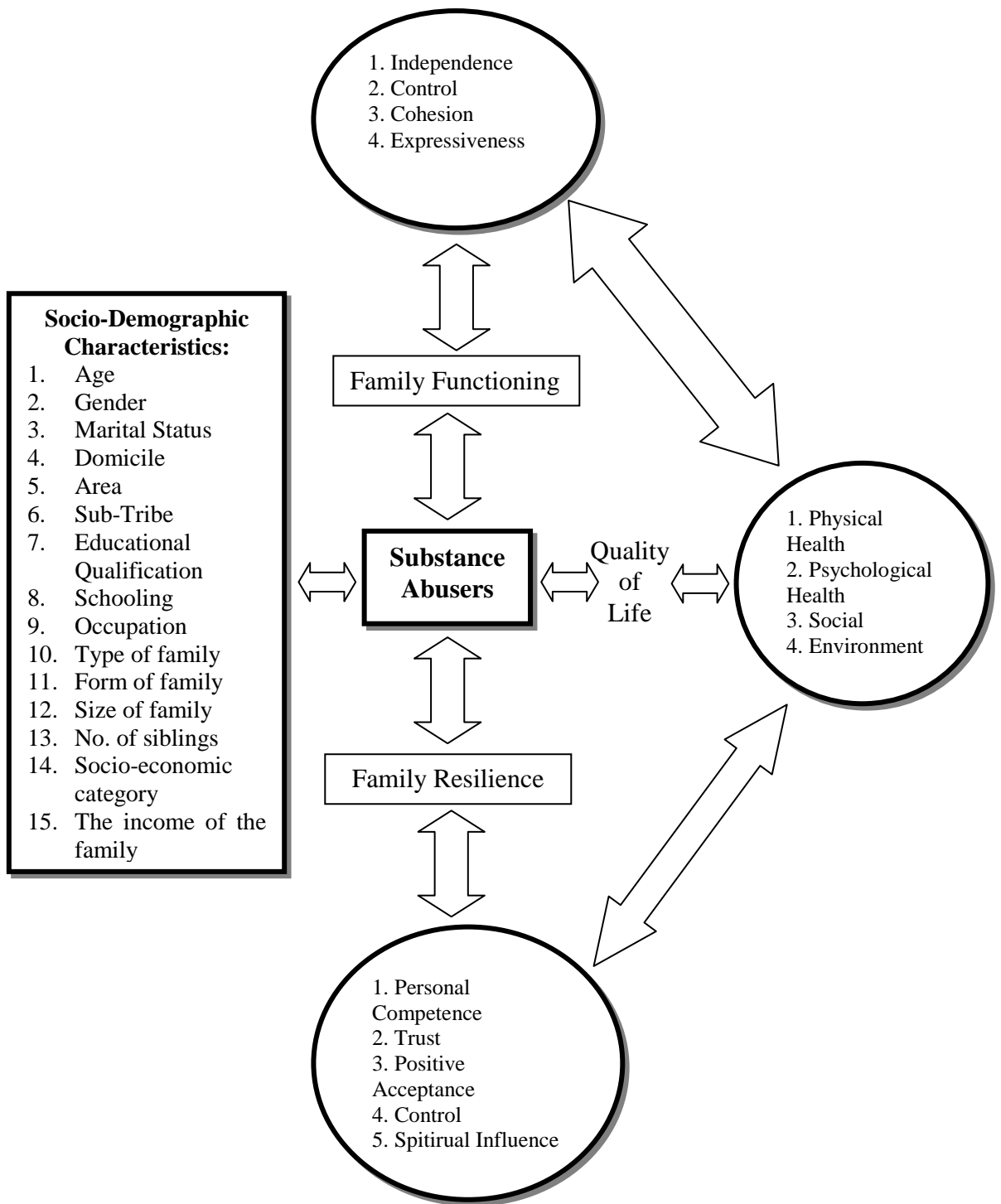
The names of all chemicals that are prohibited or controlled in India under the NDPS Act are listed in the list below. The list utilises the medications' International Nonproprietary Names (INN), but it also occasionally refers to them by their chemical names. These names refer to well-known narcotics like ganja, cocaine, heroin, etc. Any of the following substances may not be grown, produced, manufactured, possessed, sold, bought, transported, stored, consumed, or distributed unless necessary for medical or scientific research and in accordance with applicable laws, orders, and licence terms

#### **2.10 Conceptual Framework of the Study**

The conceptual framework of a study is a model built with various variables which are examined through various works of literature. After understanding the concepts, the researcher can construct the conceptual framework. As the research deals with family functioning, family resilience and quality of life among substance abusers the researcher has presented the concept as follows:

The conceptual framework portrayed here is adapted from variables based on the understanding of the researcher. In this model, the socio-demographic characteristics of the respondents, family functioning, family resilience and quality of life are displayed. As the level of family functioning rises substance abusers will have better quality of life. When the level of family resilience is high substance abusers will have better quality of life. This reveals that QOL, family functioning and family resilience are all linked and interrelated.

**Figure 3: CONCEPTUAL FRAMEWORK**



Source: Constructed by the researcher

## **2.11 Conclusion**

In the present chapter, available literature review related to the present study in terms of drugs and their types, substance abuse, its implications and solutions, family and substance abuse, family functioning, family resilience, Quality of life, national drug policies in India, theories and approaches to family intervention are discussed. There are various empirical studies on family functioning, family resilience quality of life and substance abuse. However, in the available literature, there is still a gap in studies on the relationship between Quality of Life and family functioning with substance abusers, and the relationship between Quality of Life and family resilience with substance abusers. From the analysis of the literature and various studies, the gaps, research problems and the status of substance abusers were understood. By understanding the concepts, a conceptual framework of the study has been portrayed.

Then, as a part of the research objectives, the next chapter discusses the methodology adopted for the present study.

## **CHAPTER- III**

### **METHODOLOGY**

The previous chapter focused on the review of the literature and certain research gaps within. The present chapter discusses the setting and the methodology of the study which includes the profile of the study area, de-addiction centres in Mizoram, the statement of the problem, objectives of the study, hypotheses, a pilot study, research design, tools of data collection, description of scales used in the study, selection of the sample, source of data, pre-testing, reliability of the tool, data processing and analysis, concepts and definitions, research ethics and limitations of the study.

#### **3.1 The Setting: Profile of the Study Area**

The present study is divided into two sections. The first section deals with the profile of the study area and the descriptions of de-addiction centres in Mizoram. The setting of the present study covers Aizawl, the district capital of Mizoram. The present study is conducted among substance abusers in de-addiction centres of Aizawl, Mizoram.

##### **3.1.1 The State of Mizoram**

The state of Mizoram is situated on the high hills of north eastern transitional border area of India. It is bordered by the international countries of Myanmar (Burma) on the east and south and Bangladesh on the south. It is also bounded by the states of Tripura in the west, Manipur and Assam on the north. It occupies an area of 21,087 sq. km and has a 710 km international boundary. The total population of the state is 10,97,206 according to 2011 census in which 555,339 are male and 541,867 are female. The population of Aizawl district accounts for 37.03 percent of the total population of Mizoram. The population density is 113 persons per sq.km. The people of Mizoram belong to various tribes. Each tribe has its own language and culture; however, most of the people speak Mizo language.

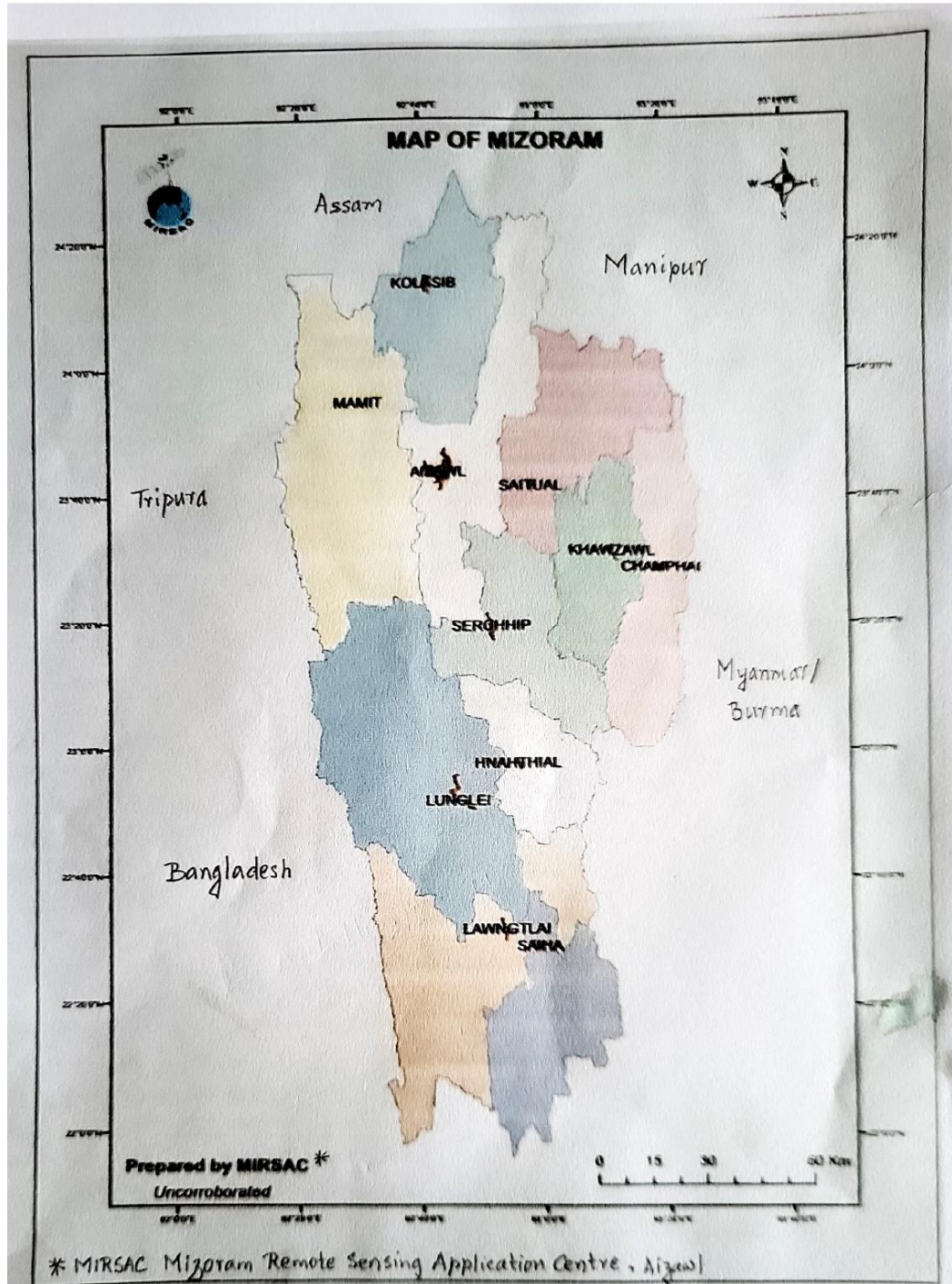
The problem of addiction or drug abuse is on the rise in the state of Mizoram. This state is most vulnerable because of its wide international boundaries and its closeness to the infamous Golden –Triangle which is noted for production and supply of heroin to the states of North East India. Though heroin had been the most abundantly used drugs but recently the trend has changed to excessive use of spasmoproxyvon and other pharmaceutical drugs (People’s Chronicle, 2017). According to the United Nations Office on Drugs and Crime (UNODC, 2013) latest Southeast Asia Opium Survey 2013 registered a 26 percent rise from 2012 in opium cultivation and yield.

Mizoram has a rugged mountain terrain and most of them are from north to south directions. Generally, Mizoram comprises primarily sandstone and shale which are laid down in deltas and river banks and no valuable mineral deposits have been discovered in Mizoram. Most of the rivers flow north-south direction and River Tlawng is the longest river in Mizoram. The rivers are fed by monsoon wind and the average rainfall reaches 254 cm per annum. The average height of the mountainranges is 900 metres.

Mizoram enjoys rich biodiversity and is one of the mega biodiversity hotspots of the world. Natural vegetation comprises tropical evergreen in the lower altitudes and semi-evergreen on the upper slopes. About 90.68 percent of the State’s total geographical area is covered under forests. The land is rich in natural resources and the State has 130 square km of very dense forest. Mizoram has abundant natural bamboo resources which cover 31 percent of its area.



Figure 4: Map of Mizoram



Source: Mizoram Remote Sensing Application Centre, Govt. of Mizoram

Figure 5: Map of the Study Area (Location Map of Mizoram State)



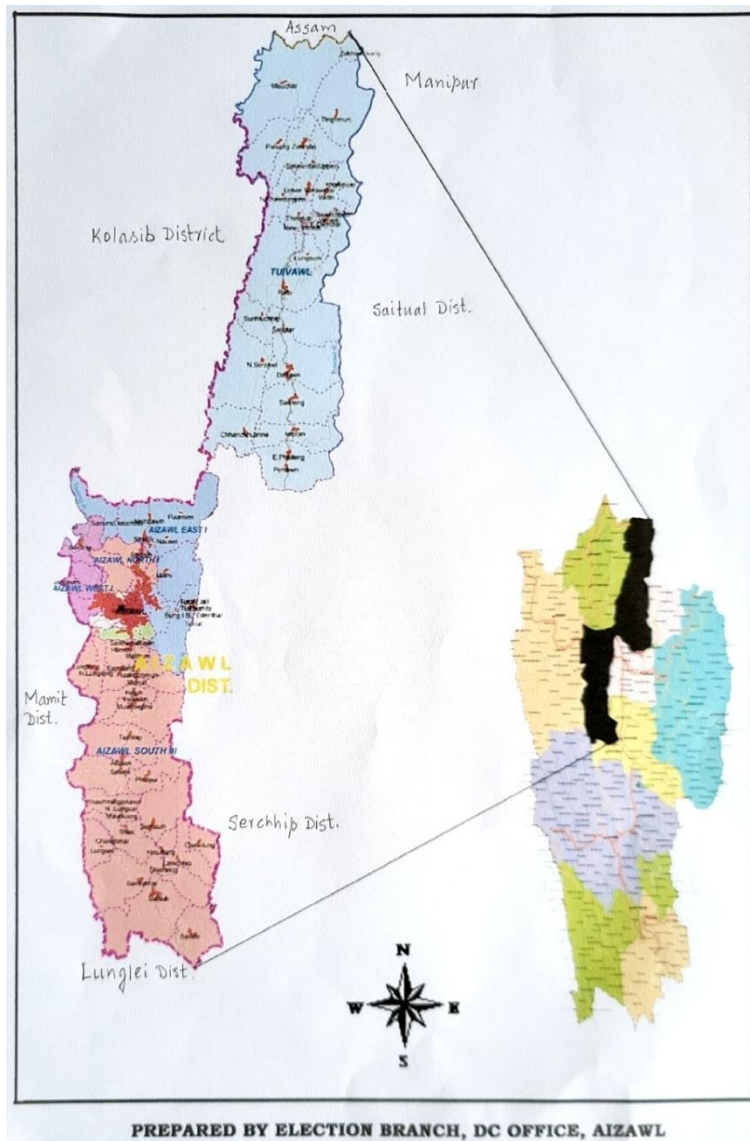
Source: <https://www.mapsofindia.com>

### 3.1.2 Aizawl District

Aizawl is the capital of Mizoram state, north-eastern India. It is situated in the north-central part of the state on a ridge at an elevation of about 2,950 feet (900 metres).

Aizawl was included in the territory that became part of the newly created Assam state in 1950. The tribal peoples of the region's Mizo Hills, however, demanded more autonomy.

**Figure 6: Map of Aizawl District**



Source: Election Branch, Office of the Deputy Commissioner, Govt. of Mizoram.

In the mid-1960s members of the Mizo National Front launched an armed attack on local government offices in Aizawl, but it was quickly suppressed by government forces. The insurgency continued, and in 1972 the Union Territory of Mizoram was created from a portion of Assam, with Aizawl as the administrative centre. Aizawl became its capital when Mizoram was re-designated as a state in 1987.

Aizawl is the most populous city in the state. Timber and bamboo are collected from the dense hillside forests. The soil cover is generally thin except in the river valleys, where rice, corn (maize), beans, tobacco, cotton, pumpkins, oilseeds, and peanuts (groundnuts) are grown. Poultry raising, hunting, fishing, and animal husbandry supplement agriculture. Aluminium utensils, hand-loomed textiles, and furniture are manufactured in the city. Electricity is generated by a diesel-powered station. Hand-weaving, blacksmithing, carpentry, basket-making, and hat-making are the main cottage industries. The city's attractions include a zoological park, the State Museum at MacDonald's Hill, and the Mizoram State Museum, a treasure house of historic relics, ancient costumes, and artefacts.

The surrounding region is a part of the Assam-Myanmar (Burma) geologic province, with the steeply inclined hill ranges trending north-south. The rapid Dhaleshwari (Tiwang), Tuivawl, and Sonai (Tuirial) rivers and their tributaries crisscross the region. The tribal peoples of the region are mostly emigrants from Myanmar, and most have become Christians. The Border Roads Organization has built many paved roads in the area. An airport handling domestic flights is to the north-west of the city. In addition, there are several protected natural areas nearby to the west, east, and south Population Census (2011).

### **3.1.3 Statement of the problem**

Drug abuse is a global phenomenon. The use of substances, in some form or another, is universal. In 2011, between 167 and 315 million people aged between 15 and 64 were estimated to have used an illicit substance in the preceding year. This

corresponds to between 3.6 and 6.9 per cent of the population. Polydrug use, especially a combination of drugs and illicit substances, continues to be a concern.

Alcohol and drug abuse has emerged as a serious concern in India. The geographical location of the country makes it highly vulnerable to the problem of drug abuse. Currently, India is not merely a country for the transit of such drugs from the 'Golden Triangle' or 'Golden Crescent'; it has also become a country of consumption (MSJ&E, 2013). As per the National Survey of Extent, Pattern and Trend of Drug Abuse in India, sponsored by the Ministry of Social Justice and Empowerment and by the United Nations Office on Drugs and Crime, Regional Office South Asia (UNODC- ROSA) in 2000-2001 and published in 2004, it was estimated that about 73.2 million persons were users of alcohol and drugs. Of these 8.7, 2.0 and 62.5 million were users of cannabis, opium and alcohol respectively. About 26%, 22% and 17% of the users of the three types respectively were found to be dependent on/addicted to them (Ray, 2004).

North-Eastern states of India, due to their geographic positioning among other several factors were vulnerable to high patterns of substance abuse. Of the eight North-Eastern states, namely Assam, Meghalaya, Sikkim, Tripura, Arunachal Pradesh, Manipur, Mizoram and Nagaland, the last four share a common international border with Myanmar, the world's second-largest illicit opium-producing country. Following the introduction of heroin in the early 1970s, within ten years, many local young males, and to a lesser extent, young females in their mid-teens started injecting heroin (Panda, 2006).

It is difficult to pinpoint the exact time when drug abuse entered Mizoram but it has been observed that the children of the rich who could afford to buy were the first victims (Ralte, 1994). In all probability, the Mizo youth who were exposed to various colleges in the metropolis of India during the 1960s and 70s experienced various drugs. It was in the later part of the 1980s when 'drug abuse' really established its foothold and drug-related health problems were recorded in Mizoram. According to the survey conducted by the Central KṬP (Youth Fellowship, Presbyterian Church) in 1998, there were 15,188 drug users in Mizoram of whom 14,

347 (94.46%) were male and 841 (5.33%) were female(Hmingthanmawii,2000). In 2013, a total of 10,750 injecting drug users were validated by the Mizoram AIDS Control Society.

Treatment centre population mapping conducted by MSD&RB in September 2012 reveals that there are 242 inmates in 10 centres funded by the Government and 1,789 inmates in 28 NGOs. Altogether, there are 2,031 inmates in drug treatment centres in Mizoram at the time of the mapping (MSD&RB, 2013). Although the family has been viewed as an important factor in the rehabilitation process there is limited research on the relationship between the family and the quality of life of substance abusers.

According to Central committee of Young Mizo Association (YMA) at least 1456 people including 156 females have died due to drug abuse (in 34 years) since 1984 till July 2017 and presently there are 2080 people affected by drugs, who have been put up at several rehabilitation centres in Mizoram. The recent tendency and trend of drug abuse is on an increase. Recently in Mizoram the pattern of drug use has shifted to the use of medicinal/pharmaceutical drugs. The main cause for this shift may be the easy availability and cheaper price of medicinal/pharmaceutical drugs. The Spasmo-proxyvon has been the most widely and popularly abused drugs followed by heroin in Mizoram. The abusers inject the suspension of water and proxyvon powder onto their other addictive material. There are many causes which are responsible for the drug abuse such as the psychological causes followed by cultural and social reasons. Curiosity, pleasure seeking, negative motivation towards life, frustration, anxiety and insurgence against parents are identified as psychological causes. Addicted respondents mentioned fashion style, peer pressure, lack of parental affection and care, broken family and media influence as the major social and cultural causes. Indulging in addiction as a fashion is another aspect contributed by addicts in Mizoram. The cities, towns and urban centres in the state are very modern and fashionable places. Regular adaptation of new styles in music, dance, and dress even in interpersonal relationship has been very common as any other normal activity. Apart from Mizoram society is very much liberal one. Among

the economic factors unemployment, easy availability of pocket money and easy source of drugs are the important ones (Joshi, 2005).

### **3.1.4 Objectives**

The objectives of the study are as follows:

1. To understand the patterns of substance abuse.
2. To assess the family functioning of substance abusers.
3. To assess the family resilience of substance abusers.
4. To examine the quality of life of substance abusers.
5. To assess the relationship between family functioning, family resilience and quality of life of substance abusers.

### **3.1.5 Hypotheses**

Family functioning can be delineated into and measured through the two constructs of cohesion and flexibility (Olson, 1989). Likewise, family resilience can be delineated into and measured through the three constructs of belief systems, family organizational patterns, and communication/problem-solving (Olson, 1989). The following hypotheses are based on the constructs of family functioning and family resilience:

1. Greater family resilience betters the quality of life of substance abusers.
2. Better family functioning better the quality of life of substance abusers.

### **3.1.6 Pilot Study**

At the beginning of the study, an extensive review of the literature regarding substance abuse, family functioning, family resilience and quality of life was done. A pilot study was then conducted with 8 (eight) workers of de-addiction centres through an interview schedule to find out the feasibility of the study. A quality discussion was also organized with them to understand the status of substance abusers in Mizoram.

## **3.2 Methodology**

The present section discusses the methodology adopted in the present study. The sub-heading includes the research design, selection of the sample, inclusion criteria, tools of data collection, sources of data, pre-testing, reliability of the tools and data processing and analysis, operational definitions, ethical considerations, limitations and chapter scheme of the present study.

### **3.2.1 Research Design**

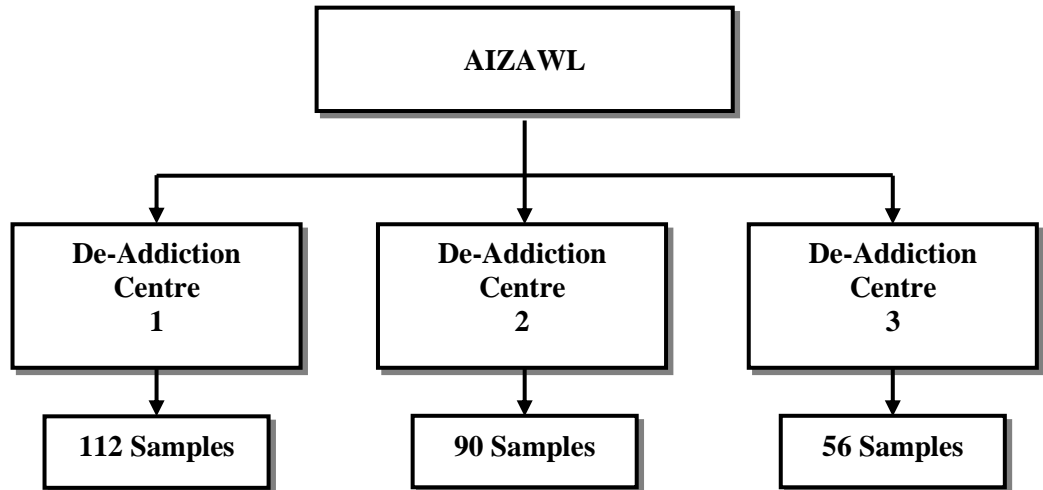
This study covered aspects related to family functioning, family resilience and quality of life among substance users in de-addiction centres in Aizawl. The study is exploratory in design and cross-sectional in nature. The number of substance abusers is not recorded and often there is no recording of substance abusers because there is unreliable data. The issue of substance abuse and in particular its relationship with family is very sensitive; hence the methodology used in this study further lent itself well to qualitative approaches, quantitative approaches are also adopted when appropriate. For the qualitative data, a Case Study and Focus Group Discussion (FGD) were conducted. The respondent's family members were taken as a unit of the study. Further, the FGD covering the beliefs, organizational patterns and communication processes were covered and the challenges faced by the respondents were discussed. Since this is a study based on individual experiences, participants were selected using systematic sampling.

### **3.2.2 Selection of Sample**

Multi-stage Sampling was adopted. In the first stage, Aizawl was purposively selected because it records the highest number of de-addiction Centers in Mizoram (MSD&RB, 2015). In the next stage, three de-addiction centres with the highest number of bed capacities were selected. In the third stage of sampling, a final sample was selected using proportionate sampling to keep gender and the centres represented. The unit of the study is individual substance abusers and family members of the respondents.



**Figure 7: Multi-Stage Sampling Diagram**



Source: Constructed by the researcher.

### **3.2.3 Inclusion Criteria**

Using the inclusion criteria listed below all substance abusers in de-addiction centres who fall within the inclusion criteria and are willing to give informed consent were chosen as the final sample. Males and females who are substance abusers and are staying in de-addiction centres who are literate and residing in Mizoram and willing to give informed consent for participation in the study are chosen.

### **3.2.4 Tools of Data Collection**

Tools are instruments used to collect data from the respondents for a study. An interview schedule was used to collect data from the respondents on the quantitative part whereas case studies and focus group discussions were conducted to collect qualitative information.

The following are the detailed descriptions of the above-mentioned tools:

- 1. Interview Schedule:** The respondents were administered an interview schedule. The interview schedule sought information on socio-demographic characteristics, family background, and the pattern of substance abuse, To

assess the family functioning the Family Environment Scale developed by Moos, R.H and Moss, B.S (1986) was used, family resilience and quality of life.

- 2. The Family Environment Scale (FES):** The Family Environment Scale (FES) was developed by Moos, R.H and Moss, B.S (1986) which also measures family functioning and consists of 90 statements and ten subscales. The subscales measure the three dimensions of family functioning which include cohesion, expressiveness and conflict, Personal Growth which includes independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation and moral-religious emphasis and system maintenance which covers organisation control subscales. The family environment scale (FES) measures (10) dimensions of the family environment however for this study, only four domains with 36 questions were used, they are - Cohesion Expressiveness, Independence, and Control. There are two possible responses, True or False. The raw score for each item on the scale was added to get a total score for the family functioning questionnaire.
- 3. Family Resilience Scale:** The family resilience scale, an adapted version of CD-RISC (Connor-Davidson Resilience Scale, 2003) was constructed by the researcher having 25 items. The raw score for each item on the scale was added to get a total score to score the ways of the coping questionnaire. There are five possible responses, 0, 1, 2, 3 and 4 which indicate 0 is not true at all; 1= rarely true; 2=sometimes true;3=often true,4=true nearly all the time.
- 4. Quality of Life WHOQOL-BREF (1997):** the standardised scale was used to assess the quality of life. There are four domains in the QOL scale, *Physical Health Domain, Psychological Domain, Social Domain and Environment Domain*. There are five possible responses 1, 2, 3, 4 and 5 which indicate 1=very poor; 2=poor; 3=neither good nor bad; 4=good; 5=very good.
- 5. Interview guide for case studies:** A case study is an in-depth study of one person, group, or event. In a case study, nearly every aspect of the subject of a person's life and history is analyzed to seek patterns and causes of

behaviour. A case study allows the researcher to collect rich information about the subjective aspects of the selected respondents about substance abusers. The interview guide for case studies focused on the family functioning as told by family members of the respondents. A guide for case studies was constructed to develop an understanding of the family functioning. Help was sought from Family Adaptability and Cohesion Scale-II (FACES-II) by Olson, in 1982 to guide the issues to be raised.

- 6. Guide for Focus Group Discussion:** A focus group discussion involves gathering people with similar illnesses or experiences together to discuss a specific topic of interest. It is a form of qualitative research where questions are asked about their beliefs, organizational patterns and communication processes. In the focus group discussion, participants are free to talk with other group members; unlike other research methods, it encourages discussions with other participants. It involves group interviewing in which a small group of 8 people participated. It was led by the moderator (researcher) in a loosely structured discussion of the selected topic. The focus group discussion guide was prepared with the help of the Family Resilience Assessment Scale (FRAS) by Sixbey (2005).

### **3.2.5 Sources of Data**

In the present study, two sources of data have been used namely primary and secondary sources of data. Primary data was collected through both quantitative and qualitative methods. The quantitative data was collected from substance abusers using an Interview Schedule to collect information related to socio-demographic characteristics, the Family Environment Scale was used to assess family functioning, family resilience and the Quality of Life (WHOQOL-BREF, 1997) standardised scale was used. The qualitative data was collected through in-depth interviews and focus group discussions, reflected by five case studies which were conducted among the family of substance abusers.

The secondary data was collected through available journal articles, books, magazines, annual reports and open-access articles with the help of web sources.

### **3.2.6 Pre-testing**

The interview schedule was prepared to collect quantitative data from the respondents in their regional language. The tool was translated with the help of a trained professional who is proficient in the Mizo language. A pre-test was conducted with 10 substance abusers in a de-addiction centre. Certain items were slightly modified to make it more comprehensive to provide insight to ask questions on the local context for social support, which achieved the purpose of the study.

### **3.2.7 Data Collection**

The data collection was conducted by the researchers during the year 2019 in two phases. In the first phase, the researcher collected the qualitative data, the researcher conducted case studies and the focus group discussion of the present study and the second phase covered the quantitative data.

### **3.2.8 Reliability of the tool**

The administered scales of measuring family functioning, family resilience and Quality of Life are tested for reliability by conducting the Cronbach alpha and Guttman spit-half tests respectively. The values are .937 and .727 for the family functioning scale. The family resilience scale was adopted by Connor Davidson (2003) and was modified and structured by the researcher in the context of Mizoram and tested for its reliability. The values are .819 and .794. The WHOQOL-BREF Scale values are .840 and .869. Since the alpha value is more than .8 it is good and the spit half value is more than .7 the tools were found to be reliable and accepted for further data collection.

### **3.2.9 Data Processing and Analysis**

The quantitative primary data collected through the Interview Schedule was edited, coded and processed with the help of Microsoft Excel and analyzed with the SPSS package. The analysed data was presented in the form of two-way tables and figures. The researcher used both descriptive statistics and non-parametric tests like Spearman's Correlation, KruskalWalley test and Mann U Whitney Test.

### **3.3 Concepts and Operational Definitions**

**Family Functioning:** Family functioning is a process in which members interact with each other to meet basic needs.

**Family Resilience:** Family resilience is the family's ability to maintain or resume effective functioning following potentially traumatic events.

**Quality of Life:** Quality of Life is the general evaluation of a person's physical, emotional and social well-being.

**Substance Abuse:** The use of a substance for a purpose, that is, not consistent with legal or medical guidelines.

**Substance Abusers:** Substance abusers are those who use illegal drugs or prescription or over-the-counter drugs or alcohol for purposes other than those for which they are meant to be used, or in excessive amounts.

**Substance Misuse:** Substance misuse refers to the use of psychoactive substances in a way that is harmful or hazardous to health. This includes alcohol and illicit drugs.

**De-addiction centre:** De-addiction centre refers to centres/homes run by NGOs where substance abusers are kept either forcibly or voluntarily to help them live a substance-free life.

### **3.4 Ethical Considerations**

The research has been carried out as per the fundamental ethical principles of research. Respondents who were willing to give informed consent for participation in the study took part in the study and confidentiality was maintained. The respondents are informed that at any point in time, they can withdraw from the research. The researcher explained the purpose of the study before interviewing the respondents. Further, no video and audio recordings were done during the data collection process.

### **3.5 Limitations of the study**

- The present study is restricted only to substance abusers in de-addiction centres.
- Not all of the substance-abusing populations are in the de-addiction centres; it may not encompass the whole substance abusers.

### **3.6 Chapter Scheme**

The report writing of the present study is organised into nine chapters. The chapter scheme is briefly discussed as follows:

#### **Chapter I: “Introduction”**

The first chapter discusses the background of the study, the basic concepts of family functioning, family resilience, quality of life and substance abuse, the global scenario of substance abuse, the Indian scenario of substance abuse, the northeast scenario of substance abuse and the Mizoram scenario of substance abuse. Further, substance abuse and family functioning, family resilience and substance abuse, and quality of life and substance abuse are being highlighted.

#### **Chapter II: “Review of Literature”**

The second chapter discusses the available literature review related to the present study in terms of drugs and their types, substance abuse, its implications and solutions, family and substance abuse, family functioning, family resilience, Quality of life, national drug policies in India, theories and approaches to family intervention, research gaps.

#### **Chapter III: “Methodology”**

The third chapter discusses the setting and the methodology of the study which includes a profile of the study area, de-addiction centres in Mizoram, a statement of the problem, objectives of the study, hypotheses, a pilot study, research design, tools of data collection, description of scales used in the study, selection of

the sample, source of data, pre-testing, reliability of the tool, data processing&analysis, concepts and definitions, research ethics and limitations of the study.

#### **Chapter IV: “Socio-Demographic Characteristics of Substance Abusers”**

The fourth chapter presents the socio-demographic characteristics of the respondents which include - the age of the respondents, marital status, educational qualification, sub-tribe, geographic characteristics of respondents, domicile of respondents, family history, familial characteristics, the respondent type of family, size of family and number of siblings and economic characteristics of the respondents such as - occupation, annual income and socio-economic status of the respondents.

#### **Chapter V: “Pattern of Substance Use”**

The fifth chapter consists of a pattern of substance use by the respondents which includes- respondents’ patterns of drug use by gender, respondents’ drug use pattern at first use by gender, respondents’ drug use pattern at 2<sup>nd</sup> use by gender, respondents’ drug use pattern at 3<sup>rd</sup> use by gender, respondents drug use pattern at 4<sup>th</sup> use by gender and respondents first time exposure of substance abuse by age group at 1<sup>st</sup> use, respondents 2<sup>nd</sup> exposure of substance abuse by age group at 2<sup>nd</sup> use, respondents 3<sup>rd</sup> exposure of substance abuse by age group at 3<sup>rd</sup> use, types of substance, age.

#### **Chapter VI: “Family Functioning of Substance Abusers”**

The sixth chapter presents the family functioning of substance abusers. The chapter is divided into two sections. The first section deals with the qualitative findings of the study. In this, four case studies of different backgrounds were conducted to understand and analyse family functioning as told by other members of the respondent’s family.

The second section discusses the quantitative findings of the study. Family functioning mean score by gender, level of family functioning by gender, area and

domicile, age and economic status by the level of family functioning, Chi-square test for association among the type of substance, age, duration and money spent at first use and level of family functioning, Chi-square test for association among the type of substance, age, duration and money spent at third use and level of spearman's inter-correlation matrix of family functioning, Mann-Whitney u test significant difference between the mean rank of gender and area across family functioning are analysed in the sixth chapter.

### **Chapter VII: “Family Resilience of Substance Abusers”**

The seventh chapter consists of “Family Resilience of Substance Abusers”. The chapter is divided into two sections. The first section deals with the qualitative findings of the study. In this, a focus group discussion was conducted to understand and analyse the family resilience as told by other members of the respondents' families. The second section consists of the quantitative findings of the study. Level of resilience by domicile and area, level of resilience by age group, socioeconomic status, annual family income and level of resilience of respondents, Chi-square test for association between family functioning and resilience, Kruskal-Wallis test for significant difference among the mean rank of resilience level concerning factors of family functioning are analysed in the second section.

### **Chapter VIII: “Quality of Life of Substance Abusers”**

This chapter is divided into two sections. This first section presents the respondents' quality of life mean scores by gender and form of family, respondents' quality of life mean scores by domicile and area, respondents' level of quality of life by gender, domicile and area, Chi-square test for association between level of quality of life by age group, level of quality of life by age group and socioeconomic status, duration and money spent at first use and level of QOL, type of substance, age, duration and money spent at 3<sup>rd</sup> use and level of QOL, Chi-square test for association between level of family functioning and quality of life, Chi-square test for association between level of family resilience and quality of life, spearman's inter correlation matrix of quality of life, Mann-Whitney U test significant difference



between mean rank of gender, domicile and area across quality of life, Kruskal-Wallis test for significant difference among mean rank of age group with respect to factors of family functioning and quality of life are presented in this chapter.

## **Chapter IX: “Conclusion”**

The ninth chapter is the last and briefly summarises the entire thesis, major findings, discussion and suggestions based on the findings of the present study.

### **3.7 Conclusion**

To conclude, the chapter has attempted to describe the setting of the study and the methodology applied for the present study in terms of the profile of the study area, de-addiction centres in Mizoram, statement of the problem, objectives of the study, hypotheses, a pilot study, research design, tools of data collection, description of scales used in the study, selection of the sample, source of data, pre-testing, reliability of the tool, data processing & analysis, concepts and definitions, research ethics and limitations of the study.

The remaining chapters will deliberate on the findings of the study.

## CHAPTER - IV

### SOCIO-DEMOGRAPHIC PROFILE OF THE RESPONDENTS

In the previous chapter, profile of the study area, statement of the problem, objectives of the study, hypotheses, a pilot study, research design, tools of data collection, description of scales used in the study, selection of the sample, source of data, pre-testing, reliability of the tool, data processing and analysis, operational definitions, research ethics and limitations of the study were discussed.

The present chapter focuses on the socio-demographic characteristics of the study respondents. Socio-demographic is a combination of social and demographic factors that define people in a specific group or population. It combines social and demographic factors such as age, sub-tribe, domicile, marital status, educational qualification, gender etc.

#### 4.1 Socio-Demographic Characteristics

This section discusses the demographic characteristics of the respondents. The characteristics of the profile of the respondent are very important in any research to understand the population studied. In this study, the characteristics of the profile of the respondents include - age, marital status, tribe/sub-tribe, and domicile.

Further, the later sections describe the socio-economic characteristics such as educational qualification, place of schooling, occupation, family income per annum and socio-economic status and familial characteristics of the respondents namely type of family, form of family, size of family and number of siblings.

Generally, demographic characteristics help us to understand the size, status, composition, and distribution of the target population of a study. **Table 1** shows the demographic profile of the respondents by gender. There are four important variables such as age, marital status, domicile and area as shown in the table.

**Table 1: Demographic Characteristic of the Respondents**

Sl. No.	Characteristics	Gender		Total N = 258
		Male n = 134	Female n = 124	
<b>1</b>	<b>Age</b>			
	Children (<14)	7 (5.22)	9 (7.26)	16 (6.20)
	Youth (14-24 )	57 (42.54)	38 (30.65)	95 (36.82)
	Adult (24- 40 )	28 (20.90)	66 (53.23)	94 (36.43)
	Middle Age (>40)	42 (31.34)	11 (8.87)	53 (20.54)
	<b>Mean ± SD</b>	32.62 ± 14.00	29.08 ± 10.72	30.92 ± 12.63
<b>2</b>	<b>Marital status</b>			
	Married	17 (12.69)	11 (8.87)	28 (10.85)
	Unmarried	75 (55.97)	60 (48.39)	135 (52.33)
	Separated	21 (15.67)	2 (1.61)	23 (8.91)
	Divorced	14 (10.45)	31 (25.00)	45 (17.44)
	Widow/widower	7 (5.22)	20 (16.13)	27 (10.47)
<b>3</b>	<b>Educational Qualification</b>			
	Primary School	18 (13.57)	17 (14.18)	33 (12.90)
	Middle School	26 (19.21)	40 (32.09)	73 (28.40)
	High School	52 (38.54)	30 (23.88)	79 (30.47)
	Higher Secondary	34 (25.47)	35 (27.61)	60 (23.39)
	College and above	4 (3.21)	2 (2.24)	13 (4.84)

Source: Computed

Figures in the Parentheses are percentages

Age is an important variable in social sciences research. The age group is classified into four categories namely, children (<14 years), youth (14-24 years), adults (25-40 years) and middle age (>40 years). Among the respondents, one-third (36.82) of them belonged to youth (14-24), with which almost half (42.54%) of males constitute a higher percentage than females (30.65%) of the respondents.

Another one-third belongs to the adult (25-40 years) in which more than half (53.23%) of females constitute a higher percentage than males (20.90%) of the respondents. One-fifth (20.54%) of the respondents belong to the middle age group (>40 years) in which male (31.34%) represents a higher percentage than female (8.87%). Children (<14 years) are very few (6.20 %) across genders where females share a little higher percentage (7.26%) than males (5.22%). The mean age for males is 33 (32.62) years and that of females is 29 (29.08) years.

By analysing the age group the majority of three-fourths (73.25%) of the respondents belong to the age group between 14-40 years in which the majority (83.88%) were female respondents. Further, the mean age of male respondents was higher than that of female respondents by three years.

Marriage is an important institution in society. It gives an important status for a person to take responsibility in the family. The marital status is classified into five categories - unmarried, married, divorced, separated, widow/widower. Among the respondents, a tenth (10.85%) of them are married, whereas male (12.69%) holds a higher percentage than female (8.87%). A majority (55.97%) of them are unmarried to males (48.39%) are lower than females (53.33%). Few of the respondents (8.91%) are separated and males (15.67%) are more in number than females (1.61%). Almost a fifth (17.44%) of the respondents are divorced with which female is higher (25.00%) than male respondents (10.45%). A tenth (10.47%) of the respondents are widows/widowers in female (16.13%) sharing a higher percentage than male (5.22%). By analyzing the marital status, the data revealed that the majority of the respondents were unmarried and also the majority of them were female.

Education is the process of teaching, learning and acquiring knowledge in an institutional set-up. The educational qualification includes illiterate, primary, middle, high school, higher secondary, graduate and above. Among the respondents, none of them was illiterate (0.00%), and almost a seventh (13.75%) of them reached primary school level, out of which there were more males (14.18%) than females (12.90%).

The respondents who reached middle school level constitute almost a fifth (19.21%) where males share a higher percentage (32.09%) than females (28.40%).

Among the respondents, almost two-fifths (38.54%) finished high school out of which females hold more (30.47%) than males (23.88%) respectively. A secondary level of education was completed by a fourth (25.47%) of the respondents of which the majority were male (17.33%) and female (23.39%) were less in number. A few (3.21%) of the respondents were graduates and above and females (4.84%) share a higher percentage than males (2.24 %). Hence, the table shows clearly the majority about fourth percent (38.54%) of the respondent's level of education was high-school.

**Table 2** shows the social characteristics of the respondents. Sub-tribes are important characteristics of a tribe. In this study, the sub-tribe is classified into seven categories namely Lusei, Ralte, Hmar, Paite, Pawi and others. Among the respondents, almost half (48.06%) of them belonged to Lusei where males (48.51%) hold a higher percentage than females (47.58%). A sixth (15.89%) of the respondents belongs to the Pawi tribe where females (17.74%) hold a higher percentage than males (14.18%). Another one-sixth of the respondents (15.12%) belonged to Ralte in which females hold a higher percentage (16.13%) than males (14.18%). Almost a sixth of the respondents belong to the remaining two sub-tribes namely- Paite (8.14%), and Hmar (6.98%) where there was not much difference between males and females. Less than a tenth (5.81%) belonged to others, where there is not much difference between males and females by analysing the sub-tribe, almost half (48.06%) of the respondents belong to the Lusei sub-tribe, this is because Lusei is the major sub-tribe in Mizo society.

**Table 2: Social Characteristics of the Respondents**

Sl. No.	Characteristics	Gender		Total N = 258
		Male n =134	Female n =124	
<b>1</b>	<b>Sub-Tribe</b>			
	Lusei	65 (48.51)	59 (47.58)	124 (48.06)
	Ralte	19 (14.18)	20 (16.13)	39 (15.12)
	Hmar	8 (5.97)	10 (8.06)	18 (6.98)
	Paite	15 (11.19)	6 (4.84)	21 (8.14)
	Pawi	19 (14.18)	22 (17.74)	41 (15.89)
	Any Other	8 (5.97)	7 (5.65)	15 (5.81)
<b>2</b>	<b>Place of Schooling</b>			
	Mizoram	113 (84.33)	106 (85.48)	219 (84.88)
	Outside Mizoram	21 (15.67)	18 (14.52)	39 (15.12)
<b>3</b>	<b>Domicile</b>			
	Urban	99 (73.88)	120 (96.77)	219 (84.88)
	Rural	35 (26.12)	4 (3.23)	39 (15.12)
<b>4</b>	<b>Area</b>			
	Core	104 (77.61)	106 (85.48)	210 (81.40)
	Periphery	30 (22.39)	18 (14.52)	48 (18.60)

Source: Computed

Figures in the Parentheses are percentages

School is a place where one gets an education and socialise, the place of schooling plays a vital role in one's life. The place of schooling is classified into two categories in this study -Mizoram and outside Mizoram. Among the respondents, more than three-fourths (84.88%) studied in Mizoram, where females (85.48%) share a higher percentage than males (84.33%). A sixth of them (15.12%) studied outside Mizoram with which males (15.67%) represent a higher percentage than females

(14.52%). By analysing the place of schooling of the respondents, we can conclude that the majority (84.88%) of the respondents studied in Mizoram.

In an agrarian society like India, the general population can broadly be divided into rural and urban based on their settlements. Among the respondents, more than three-fourths (84.88%) were from an urban area, where female (96.77%) shares a higher percentage than male (73.88%). A sixth of them (15.12%) were from rural areas where male (26.12%) represents a higher percentage than females (3.23%). By analyzing the domicile of the respondents, we can conclude that the majority of the respondents (84.88%) were from urban areas.

The core and periphery theory explains that the core is a central region in an economy with high population density while the periphery is an outlying region with a sparse population. Among the respondents, more than three-fourths (81.40%) were from the core area, where female (85.48%) shares a higher percentage than male (77.61%). More than a sixth of them (18.60%) were from periphery areas where male (22.39%) represents a higher percentage than females (14.52%). By analyzing the domicile of the respondents, we can conclude that the majority of the respondents (81.40%) were from core areas.

**Table 3** shows the economic characteristics of the respondents. An economic characteristic is an important aspect of determining the living conditions of a people. There are four important variables such as - occupation, annual income, and socio-economic category. Occupation is classified into five categories Government employee, private employee, unemployed and others. Among the male respondents, two-fifths (35.82%) are unemployed and privately employed (38.06%) and two other occupational categories – government employee (15.67%) and others (10.45%) constitute less than a fifth each. Among the female respondents, more than half (58.06%) are unemployed, almost two-fifths (37.10%) are privately employed and a few are government-employed (3.23%) and others (1.61%) each. This shows that almost half of the respondents are unemployed.

**Table 3 Economic Characteristics of the Respondents**

Sl. No.	Characteristics	Gender		Total N = 258
		Male n =134	Female n =124	
<b>1</b>	<b>Occupation</b>			
	Unemployed	48 (35.82)	72 (58.06)	120 (46.51)
	Government Employee	21 (15.67)	4 (3.23)	25 (9.69)
	Private Employed	51 (38.06)	46 (37.10)	97 (37.60)
	Other	14 (10.45)	2 (1.61)	16 (6.20)
<b>2</b>	<b>Annual Family Income</b>			
	Low - (< Rs 70000)	68 (50.75)	62 (50.00)	130 (50.39)
	Lower Middle - (Rs 70000-300000)	27 (20.15)	26 (20.97)	53 (20.54)
	Upper middle - (Rs 300000-8.5 lakhs)	33 (24.63)	23 (18.55)	56 (21.71)
	High - (>Rs.8.5 lakhs)	6 (4.48)	13 (10.48)	19 (7.36)
	<b>Mean ± SD</b>	160268.66 ± 170511.269	198354.84 ± 229818.175	178573.64 ± 201711.462
<b>3</b>	<b>Socio Economic Status</b>			
	AAV	11 (8.21)	21 (16.94)	32 (12.40)
	BPL	71 (52.99)	55 (44.35)	126 (48.84)
	APL	52 (38.81)	48 (38.71)	100 (38.76)

Source: Computed

Figures in the Parentheses are percentages

Annual income is classified into four categories such as low (Rs.<70,000), lower middle (Rs.70,000-2,00,000), upper middle (Rs. 2,00,000 – 5,00,000) and high (Rs.5,00,000-10,00,000). Among the male respondents, half (50.75%) belong to the low, a fifth (20.15%) belong to the lower middle, more than a fifth (24.63%) belong to upper middle income and a few (4.48%) belong to high income. Among the female respondents, half (50%) belong to the low, a fifth (20.97%) belong to the lower middle, less than a fifth (18.55%) belong to the upper middle and a few



(7.36%) of the m have high annual income. The mean annual income is Rs.1,78,573.64/-.

Socio-economic Status has three categories such as AAY, BPL and APL. Among the respondents almost half (48.84%) belong to the BPL category in which (52.99%) are male and (44.35%) are female, two fifths (38.76%) belong to the APL Family in which males and females do not have much difference (38.81%) and (38.71%) respectively. More than a tenth (12.40 %) belonged to the AAY with which a few (8.21%) are male and less than a fifth (16.94%) are female.

From the above table, it can be seen that half of them belong to the low-income category (50.39%) and only a few (7.36%) belong to the high income. This indicates that substance abusers in Mizoram families with a high level of income are not as frequent in de-addiction centres as compared to those with low income.

**Table 4** shows the familial characteristics of the respondents. Family is a basic social unit in any society. The family system plays a vital role in practising the norms and value systems of their traditions based on the community. Table 4.5 shows the family characteristics of the respondents. There are four important variables such as type of family, the form of family, size of the family and number of siblings. The type of family is classified into two categories nuclear family and joint family. Among the male respondents, the majority (93.28%) belong to the nuclear family and a few (6.72%) belong to a joint family. Among the female respondents, the majority (92.74%) belong to the nuclear family and a few (7.26%) belong to a joint family. The form of the family is classified into two categories namely stable and unstable. Almost three fourth (74.03%) belongs to an unstable family while a fourth (25.97%) belongs to a stable family. This shows that unstable families are most common among substance abusers.

**Table 4: Familial Characteristics of the Respondents**

Sl.No	Characteristics	Gender		Total N = 258
		Male n = 134	Female n =124	
1	<b>Type of Family</b>			
	Nuclear	125 (93.28)	115 (92.74)	240 (93.02)
	Joint	9 (6.72)	9 (7.26)	18 (6.98)
2	<b>Form of family</b>			
	Stable	98 (73.13)	93 (75.00)	191 (74.03)
	Unstable	36 (26.87)	31 (25.00)	67 (25.97)
3	<b>Size of Family</b>			
	Small (1-3)	36 (26.87)	33 (26.61)	69 (26.74)
	Medium(4-6)	91 (67.91)	82 (66.13)	173 (67.05)
	Large (7 and above)	7 (5.22)	9 (7.26)	16 (6.20)
	<b>Mean ± SD</b>	<b>4.96±1.519</b>	<b>4.90±1.489</b>	<b>4.93±1.502</b>
4	<b>Number of siblings</b>			
	Nil	44 (32.84)	41 (33.06)	85 (32.95)
	1-2	18 (13.43)	17 (13.71)	35 (13.57)
	3-4	66 (49.25)	56 (45.16)	122 (47.29)
	5 and above	6 (4.48)	10 (8.06)	16 (6.20)
	<b>Mean ± SD</b>	<b>2.04±1.676</b>	<b>2.11±1.763</b>	<b>2.08±1.716</b>

Source: Computed

Figures in the Parentheses are percentages

The size of the family is classified into small (1-3), medium (4-6) and large (7+) families. Among the male respondents, more than a fourth (26.87%) belong to a small family, more than half (67.91%) belong to a medium-sized family and a few (5.22%) belong to a large family. Among the female respondents, more than half (67.05%) belong to a medium size family, more than a fourth (26.74%) belong to a small size family and a few (6.20%) belong to a large family.

The numbers of siblings are classified into four categories - no siblings, 1-2 siblings, 3-4 siblings and 5 and above children. Among the male respondents, a third (32.84%) do not have any siblings, a tenth (13.43%) of the respondents have 1 or 2 siblings, almost half (49.25%) of them have 3 to 4 siblings and a few (4.48%) have 5 or more siblings. The mean size of the family is 5 (4.93) and the mean number of siblings is 2 (2.08), which means the average size of the family is 5 and the average number of children in a family is two. This shows that a medium family is the common form of family in Mizo society.

From the table, it is found that the vast majority of the families (93.02%) belong to nuclear families and more than half (67.05%) of the respondents belong to medium size family. This is because the nuclear family and medium-sized family are more common in Mizo society. Almost a quarter of the respondents have no siblings, more than two-fifths have 3 to 4 siblings and only a few of the respondents have 5 or more siblings. This shows that a large family is not common among the Mizo family.

**Table 5** shows the descriptive statistics of the respondents. Age is an important variable in social sciences research. The age group is classified into four categories namely, children (<14 years), youth (14-24 years), adults (25-40 years) and middle age (>40 years). The mean age for the respondents is 31 (30.92) which indicates that most of the respondents are youth substance abusers. The mean size of the family is 5 (4.93) and the mean number of siblings is 2 (2.08) which reflects that large family is not common in Mizo society. The mean annual family income stands at Rs.1,78,573/- which indicates that in de-addiction centres most clients are in the lower-middle economic category.

**Table 5: Descriptive Statistics of the Respondents**

<b>Variables</b>	<b>N</b>	<b>Min.</b>	<b>Max.</b>	<b>Mean</b>	<b>SD</b>
Age (Years)	258	9	66	30.92	12.636
Size of Family	258	3	11	4.93	1.502
No.of Siblings	258	0	9	2.08	1.716
Annual Family Income (Rs.)	258	24000	960000	178573.64	201711.462
Age at first use of Substance Abuse (Years)	258	9	17	11.67	2.500
Duration in months use of substance Abuse	258	3	36	11.70	8.432
Amount spent per day	258	20	1000	450.04	240.387

Source: Computed

Figures in the Parentheses are percentages

The maximum age (17 years) at first substance abuse shows that substance abusers in de-addiction centres start their first use while they are in their prime youth which indicates that youth are vulnerable to substance use as it is an age group where most substance abusers are introduced to their first substance.

The mean duration in months of substance abuse is 12 (11.67) which is about a year. This indicates that most of the respondents have a higher chance of letting go of their substances.

There is a huge gap between the amount spent on substances per day as the minimum stands at 20 rupees while the maximum stands at Rs.1000 this reflects that the choice of substances has a huge influence on money spent and the daily dose is a contributing factor.

**Table 6** shows the parental profile of the respondents by gender. Parents Education: Parental education is classified into illiterate, primary, middle, high school, higher secondary, graduate and above. Most of the male and female respondent's fathers have attained education up to high school standards (94.03%) and (92.74%) respectively. A few of the parents are illiterate, male respondents' fathers (5.97%) and female respondents' fathers (7.26%).

**Table 6: Parental Profile of the Respondents by Gender**

Sl. No.	Characteristics	Gender		Total N = 258
		Male n = 134	Female n = 124	
<b>I</b>	<b>Father's Education</b>			
	Illiterate	8 (5.97)	9 (7.26)	17 (6.59)
	High School	126 (94.03)	115 (92.74)	241 (93.41)
<b>II</b>	<b>Father's Occupation</b>			
	Unemployed	8 (5.97)	9 (7.26)	17 (6.59)
	Govt Employee	39 (29.10)	35 (28.23)	74 (28.68)
	Privately Employed	87 (64.93)	80 (64.52)	167 (64.73)
<b>III</b>	<b>Father's Monthly Income</b>			
	Low (<Rs. 5,000)	8 (5.97)	9 (7.26)	17 (6.59)
	Middle (Rs. 5,000- Rs. 25,000)	89 (66.42)	82 (66.13)	171 (66.28)
	High (Rs. 25,000- 45,000)	37 (27.61)	33 (26.61)	70 (27.13)
<b>I</b>	<b>Mother's Education</b>			
	Middle School	8 (5.97)	9 (7.26)	17 (6.59)
	High School	126 (94.03)	115 (92.74)	241 (93.41)
<b>II</b>	<b>Occupation</b>			
	Business	8 (5.97)	9 (7.26)	17 (6.59)
	Govt. Employee	37 (27.61)	33 (26.61)	70 (27.13)
	Privately Employed	89 (66.42)	82 (66.13)	171 (66.28)
<b>III</b>	<b>Mother's Monthly Income (Rs.)</b>			
	Low (<Rs. 5,000)	89 (66.42)	82 (66.13)	171 (66.28)
	Middle (Rs. 5,000- Rs. 25,000)	8 (5.97)	9 (7.26)	17 (6.59)
	High (Rs. 25,000- 45,000)	37 (27.61)	33 (26.61)	70 (27.13)

Source: Computed

Figures in Parentheses are Percentages

While in the case of mothers' education, there are no illiterate, there is not much difference between mothers of male and female respondents in high school (94.03%) for males and (92.74%) for females respectively. A few (5.97%) male respondents' mothers and (7.26%) female respondents' mothers have attained education up to middle school level.

Parents' occupation is classified into four categories farming, Government employee, privately employed and unemployed. Most of the male and female respondent's fathers are privately employed (64.93%) and (64.52%) respectively. A few are unemployed, unemployed male respondents' fathers (5.97%) and female respondents' fathers (7.26%). In the case of mothers' occupation, there are no unemployed. A few mothers are in business (5.97%) and (7.26%) male and female respondents' mothers respectively. More than a fourth of male respondents' fathers are government employees (29.10%) and more than a fourth of female respondents' fathers (28.23%) are government employees. More than a fourth of male respondents' mothers are government employees (27.61%) and more than a fourth of female respondents' mothers (26.61%) are government employees.

Parents' monthly income is classified into four categories Low (<Rs. 5,000), Middle (Rs. 5,000- Rs. 25,000) and High (Rs. 25,000- 45,000) respectively. Most of the male and female respondent's fathers earn Rs.5000-25000 (66.42%) and (66.13%) respectively. A few are low earners, male respondents' fathers (5.97%) and female respondents' fathers (7.26%). More than a fourth of male respondents' fathers are high earners (27.61%) and a fourth of female respondents' fathers (26.61%) earn the same. Most of the male and female respondent's mothers are low earners (66.42%) and (66.13%) respectively. More than a fourth are high earners female respondents' mothers (27.61%) and female respondents' mothers (26.61%) respectively. A few female respondents' mothers are high earners (5.97%) and a few female respondents' mothers (7.26%) earn the same.

## 4.2 Conclusion

The present chapter discusses the socio-demographic characteristics of the study respondents. Socio-demographic is a combination of social and demographic factors that define people in a specific group or population. It combines social and demographic factors such as age, sub-tribe, domicile, marital status, educational qualification, gender etc.

The majority (73.25%) of the respondents belong to the age group between 14- 40 years with which the majorities (83.88%) were female respondents. The mean age of male respondents was higher than that of female respondents by three years. A majority (38.54%) of the respondent's level of education was high-school.

Almost half (48.06%) of the respondents belong to the Lusei sub-tribe, this is because Lusei is the major sub-tribe in Mizo society. The area of the respondents shows that the majority of the respondents (84.88%) were from urban areas, majority of the respondents (81.40%) were from core areas.

Half of them belong to the low-income category (50.39%) and only a few (7.36%) belong to the high income. This indicates that substance abusers in Mizoram families with a high level of income are not as frequent in de-addiction centres as compared to those with low income.

The majority of the families (93.02%) belong to nuclear families and more than half (67.05%) of the respondents belong to medium size family. This is because the nuclear family and medium-sized families are more common in the Mizo society.

This shows that a large family is not common among the Mizo family. There is a huge gap between the amount spent on substances per day as the minimum stands at 20 rupees while the maximum stands at Rs.1,000 this reflects that the choice of substances has a huge influence on money spent and the daily dose is a contributing factor.

Parents' education, parents' occupation and parents' income show that a few of the parents are illiterate, most of the parents are privately employed and the majority of the fathers are middle earners while the majority of the mothers are low earners.

The next chapter focuses on the pattern of substance use among substance abusers.



## CHAPTER - V

### PATTERNS OF SUBSTANCE USE AMONG SUBSTANCE ABUSERS

In the previous chapter, the socio-demographic profile of the respondents includes age, marital status, educational qualification, sub-tribe, economic characteristics of the respondents, familial characteristics of the respondents, descriptive statistics of respondents and parental profile of the respondents. This chapter discusses the patterns of substance abuse among substance abusers, drug use pattern at first use by gender, drug use pattern at second use by gender, drug use pattern at third use by gender, and drug use pattern at fourth use by gender.

#### 5.1 Descriptive statistics on patterns of substance use of substance abusers

This section discusses the patterns of substance abuse among substance abusers, their drug use pattern at first use by gender, drug use pattern at second use by gender, drug use pattern at third use by gender, and drug use pattern at fourth use by gender.

**Table 7: Descriptive Statistics of Patterns of Drug Use by Gender**

<b>Characteristics</b>	<b>Gender</b>				<b>Total N = 258</b>	
	<b>Male n = 134</b>		<b>Female n = 124</b>			
	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>
Age at 1 <sup>st</sup> Use	11.82	2.62	11.52	2.37	11.67	2.50
Duration in Months	11.97	8.82	11.40	8.02	11.70	8.43
Money Spent	44.10	24.72	46.05	24.09	45.04	24.39
Age at 2 <sup>nd</sup> Use	14.78	4.37	14.19	4.68	14.49	4.52
Duration in months	17.87	10.42	17.13	10.03	17.51	10.22
Money Spent	54.70	28.78	53.63	29.20	54.19	28.93
Age at 3 <sup>rd</sup> Use	18.83	3.30	18.75	3.11	18.79	3.21
Duration in Months	75.13	45.06	70.94	50.14	73.12	47.52
Money Spent	167.01	135.39	205.08	151.56	185.31	144.37
Age at 4 <sup>th</sup> Use	20.85	3.79	20.56	3.41	20.74	3.64
Duration in months	60.77	24.05	60.91	23.83	60.82	23.88
Money Spent	185.58	57.79	181.25	48.19	183.84	54.01

Source: Computed

**Table 7** shows descriptive statistics of the respondents' patterns of drug use by gender. Gender is used to describe the characteristics of women and men that are socially constructed. The domain can be divided into four sub-categories such as- First use -Age, duration in months and money spent, Second Use - Age, duration in months and money spent, Third Use - Age, duration in months and money spent, Fourth Use - Age, duration in months and money spent.

The respondents' first use mean age is 12 (11.5) years which is in the children age category (<14) in which the male 12(11.82) years and female 12(11.52) years. There is no difference between male female. In the first use, the mean duration of use in months is (11.70) years, which is almost a year. There is not much difference between males (11.97) and females (11.40). Money spent is not much in the first use, the mean score is (45.09) rupees, and with males spending 44.10 rupees and females spending Rs. 46.05 this indicates that no matter the substances the amount/dosage cannot be high.

In the second use, the respondents' mean age is 14.49 years which is in the youth category (14-24) in which the male (14.78) and female (14.19) have not much difference. The duration of use in months in the second use is (17.51) which is more than a year and 6.11 months longer than the first use duration in months use the mean duration of use in months is 11.70. There is not much difference between males (11.97) and females (11.40). The mean sum of money spent is also increasing in the second use Rs.54.19, the average mean for money spent by a male is Rs. 55 (54.73) and female (53.63). This indicates that the substance use or the amount/dosage used by males and females do have not much difference.

In the third use, the respondents' mean age is 19 (18.79) years which is in the youth category (14-24) in which the male 15 (14.78) years and female (14.19) have not much difference. The duration of use in months in the second use is 18 (17.51) months which is one and half year and 6.11 months longer than the first use duration in months use the mean duration of use in months is 11.70. There is not much difference between males (11.97) and females (11.40). The mean sum of money spent also increased in the second use by Rs. 54.19, the average mean for

money spent by a male is Rs.54.73 and for females Rs.53.63. This indicates that the substance use or the amount/dosage used by males and females do have not much difference.

In the fourth use, the respondents' mean age is 21 (20.74) years which is still in the youth age, category (14-24) and indicates that youth is a vulnerable group for substance abuse in which the male 21 (20.85) and female 21 (20.56) years have not much difference. The mean for duration of use in months in the fourth use is 21 (20.74) which is almost two years of use. There is not much gender difference, male (20.85) and female (20.56). The mean sum of money spent is Rs.183.84, the average mean for money spent by a male is Rs.185.58 and for females is Rs.183.84.

**Table 8: Respondents' Drug Use Pattern at First Use by Gender**

Sl. No.	Characteristics	Gender		Total N = 258
		Male n = 134	Female n = 124	
<b>I</b>	<b>Type of Substance</b>			
	Alcohol	39 (29.10)	30 (24.19)	69 (26.74)
	Cannabis	36 (26.87)	27 (21.77)	63 (24.42)
	Dendrite	59 (44.03)	67 (54.03)	126 (48.84)
<b>II</b>	<b>Age Group at 1<sup>st</sup> Use</b>			
	Children (9-14 Yrs.)	104 (77.61)	104 (83.87)	208 (80.62)
	Adolescence (14-18 Yrs.)	30 (22.39)	20 (16.13)	50 (19.38)
<b>III</b>	<b>Duration of 1<sup>st</sup> Use</b>			
	<6 Months	43 (32.09)	41 (33.06)	84 (32.56)
	6- 12 Months	69 (51.49)	63 (50.81)	132 (51.16)
	12-18 Months	8 (5.97)	10 (8.06)	18 (6.98)
	>24 Months	14 (10.45)	10 (8.06)	24 (9.30)
<b>IV</b>	<b>Mode 1<sup>st</sup> Use</b>			
	Oral	134 (100.00)	124 (100.00)	258 (100.00)

Source: Computed

Figures in Parentheses are Percentages

**Table 8** shows the Respondent's drug use patterns at first use by gender. The respondent's drug use pattern at first use by gender includes the type of substance such as alcohol, cannabis, dendrite, age group at first use – children (9-14years) and adolescents (14-18 years), duration of first use - <6months, 6-12 months, 12-18 months, >24 months and mode of first use.

Dendrite has the highest number of users, with almost half of the male respondents (44.03%), and more than half (54.03%) of the female users. The second highest substance of abuse by male respondents is alcohol which is more than a fourth of the male respondents (29.10%) while the second highest substance of abuse is cannabis at a fourth among the female respondents (24.19%). Cannabis has the lowest number of users among male respondents, which is more than a fourth of the respondents (26.87) while dendrite has the lowest number of users among females, which is more than a fourth of the respondents (21.77%).

The age group at first use shows that the majority of the male (77.61%) started their substance use while they were in the age group between 9 and 14 years. In the case of female respondents, most of the females started their substance use while they were children (9-14 years). More than a fourth (22.39%) of the male respondents started their substance use while they were in the adolescent stage and less than a sixth (16.13%) of the female respondents had their first substance while they were adolescents. The majority (83.87%) of the female respondents started their first substances while they were children. This shows that children and adolescents are vulnerable to substance abuse.

The duration of first use is an indicator that shows how invested they are in their first substances. Among the male and female respondents, more than half (51.49%) male and (50.81%) female respectively use their substances for 6-12 months. A third of the male (32.09%) and female (33.06%) respondents used their substances for less than 6 months and a few of the male respondents(5.97%) and (10.45%) used for 12-18 months and >24 months respectively. A few of the female respondents (8.06%) used their substance for 12-18 months and >24 months respectively. The mode of use is oral for all the respondents (100%).

The table clearly shows that all the respondents took their first substance orally; the majority of the respondents used their first substance for about 6-12 months while only a few chose to use it longer.

**Table 9: Respondents' Drug Use Pattern at 2<sup>nd</sup> Use of by Gender**

Sl. No.	Characteristics	Gender		Total N = 258
		Male n = 134	Female n = 124	
<b>I</b>	<b>Type of Substance</b>			
	Alcohol	1 (0.75)	0 (0.00)	1 (0.39)
	Cannabis	64 (47.76)	73 (58.87)	137 (53.10)
	Cough Syrup	69 (51.49)	51 (41.13)	120 (46.51)
<b>II</b>	<b>Age Group 2<sup>nd</sup> Use</b>			
	Children (9-14 Yrs.)	67 (50.00)	75 (60.48)	142 (55.04)
	Adolescence (14-18 Yrs.)	36 (26.87)	24 (19.35)	60 (23.26)
	Young Adult (18-24 Yrs.)	31 (23.13)	24 (19.35)	55 (21.32)
	Older Adult (24+Yrs.)	0 (0.00)	1 (0.81)	1 (0.39)
<b>III</b>	<b>Duration of 2<sup>nd</sup> Use</b>			
	<6 Months	1 (0.75)	2 (1.61)	3 (1.16)
	6- 12 Months	100 (74.63)	95 (76.61)	195 (75.58)
	>24 Months	33 (24.63)	27 (21.77)	60 (23.26)
<b>IV</b>	<b>Money Spent 2<sup>nd</sup> Use/day</b>			
	<50 Rs/day	101 (75.37)	94 (75.81)	195 (75.58)
	Rs. 50-100	33 (24.63)	30 (24.19)	63 (24.42)
<b>V</b>	<b>Mode of Substance Use</b>			
	Oral	134 (100.00)	124 (100.00)	258 (100.00)

Source: Computed

Figures in Parentheses are Percentages

**Table 9** shows the respondent's drug use pattern at 2<sup>nd</sup> use by gender, the table includes five variables such as type of substance – alcohol, cannabis, cough syrup, age group of second use – children (9-14 years), adolescents (14-18 years) young adult (18-24 years), older adult (24+years), duration of second use - <6months, 6-12 months, 12-18 months, >24 months, daily money spent on substance and mode of substance use.

The types of second abuse of substances are alcohol, cannabis, and cough syrup, the age group of second use are Children (9-14 years), Adolescents (14-18 years), Young Adults (18-24 years), and Older Adult (24+ years). Duration of the second use - < 6 months, 6-12 months, 12-18 months, >24 months, daily money spent- <Rs. 50, Rs 50-100 and mode of substance use.

The age group of second use shows that half (50%) of the male respondents started their second substance while were children while more than half (60.48%) of the female respondents started their second substance while they were children. In the adolescent age group, more than a fourth (26.87%) of male respondents started their second substance while less than a fifth (19.35%) started their substances. Between the age group of 18-24 years less than a fourth of the male respondents (23.13%) started their second substance while less than a fifth (19.35%) of the female respondents started their second substance. Only a few (0.81%) of the female respondents started their second substance in the older adult (24+ years), while in the case of the male respondent, none of the respondents started their second substance in this age group.

The duration of use shows that the majority (74.63%) of the male respondents and the majority (76.61%) of the female respondents use their second substance of choice for 6-12 months respectively. Less than a fourth of both males (24.63%) and females (21.77%) use their second substances for more than 24 months. Only a few of the male (0.75%) and female respondents (1.61%) used their second substance in less than 6 months.

The daily money spent category shows that the majority of the male (75.37) and female (75.81) respondents spent less than 50 rupees daily while less than a third of the male (24.63) and female respondents (24.19) spent between 50-100 rupees daily. For all of the respondents (100%) their mode of use is oral. This table shows that the second choice of substance use is alcohol cannabis and cough syrup it clearly shows that there is not much difference between the males and females in age group, duration of use, daily money spent and mode of use. It indicates that more than half of the respondents started their second substance while they were children, most of the respondents used their second choice of substance for 6-12 months and all of them took their substances orally.

**Table 10** shows the respondents' drug use pattern at 3<sup>rd</sup> use by gender. The table includes five variables as Type of substance – Alcohol, and SpasmoProxyvon, Age group of second use – children (9-14 years), adolescence (14-18 years) young adult (18-24 years), duration of 3<sup>rd</sup> use - <6months, 6-12 months, 12-18 months, >24 months, Daily money spent on substance – Rs.50, Rs. 50-100, Rs.100-200, Rs.200-500 and mode of substance use.

The type of substance use shows that the majority of the male (70.90%) and female respondents (75.81%) use alcohol. Less than a third of the male (29.10%) and female (24.19%) respondents use spasmoproxyvon.

The age group of third use shows that more than half (52.24%) of the male respondents started their third substance in their young adulthood while half (50.81%) of the female respondents started their third substance in their young adulthood. In the adolescent age group more than a third (36.57%) of male respondents started their third substance and more than a third (39.52%) started their third substance. Among the respondents, a few of the male respondents (11.139%) and a few (9.68%) of the female respondents started their third substance while they were children.

**Table 10: Respondents' Drug Use Pattern at 3<sup>rd</sup> Use of by Gender**

Sl. No.	Characteristics	Gender		Total N = 258
		Male n = 134	Female n = 124	
<b>I</b>	<b>Type</b>			
	Alcohol	95 (70.90)	94 (75.81)	189 (73.26)
	SpasmoPoxyvon	39 (29.10)	30 (24.19)	69 (26.74)
<b>II</b>	<b>Age Group 3<sup>rd</sup> Use</b>			
	Children (9-14 Yrs.)	15 (11.19)	12 (9.68)	27 (10.47)
	Adolescence (14-18 Yrs.)	49 (36.57)	49 (39.52)	98 (37.98)
	Young Adult (18-24 Yrs.)	70 (52.24)	63 (50.81)	133 (51.55)
<b>III</b>	<b>Duration of 3<sup>rd</sup> Use</b>			
	<6 Months	4 (2.99)	5 (4.03)	9 (3.49)
	6- 12 Months	7 (5.22)	18 (14.52)	25 (9.69)
	12-18 Months	2 (1.49)	0 (0.00)	2 (0.78)
	18-24 Months	2 (1.49)	0 (0.00)	2 (0.78)
	>24 Months	119 (88.81)	101 (81.45)	220 (85.27)
<b>IV</b>	<b>Money Spent on 3<sup>rd</sup> Use</b>			
	<50 Rs/day	43 (32.09)	32 (25.81)	75 (29.07)
	Rs. 50-100	26 (19.40)	18 (14.52)	44 (17.05)
	Rs. 100-200	38 (28.36)	31 (25.00)	69 (26.74)
	Rs. 200-500	27 (20.15)	43 (34.68)	70 (27.13)
<b>V</b>	<b>Mode of Substance Use</b>			
	Oral	95 (70.90)	94 (75.81)	189 (73.26)
	Injections	39 (29.10)	30 (24.19)	69 (26.74)

Source: Computed

Figures in Parentheses are Percentages



The daily money spent on the third substance shows that less than a third of the male respondents spent less than Rs.50 (32.09%), Rs. 50-100(19.40%), Rs. 100-200(28.36%), Rs. 200-500(20.15%) respectively. Among the female respondents, a fourth (25.81%) of the female respondents spent less than Rs. 50, a sixth (14.52%) of them spent between Rs. 50-100, a fourth (25.00%) spent Rs. 100-200 and more than a third (36.68%) spent Rs. 200-500. The mode of substance use is oral and injection.

The table shows that the types of third substance choices are alcohol and spasmoproxyvon. There is not much difference among the male and female respondents in their age group, duration of use and mode of substance use. However slight differences between the male and female respondents can be seen in the amount of money spent daily. This reflects that there can be differences in their choice of substance and their daily dosages.

**Table 11** shows the respondents' drug use pattern and 4th use by gender. The table includes five variables as Type of substance – No response, Heroin, Cough syrup Spasmoproxyvon and ParvonSpas Age group of second use – children (9-14 years), adolescents (14-18 years) young adults (18-24 years) and older adult (18-24 years). Duration of 4th use - < 6 months, 6-12 months, 12-18 months, >24 months, Daily money spent on substance – Rs.50, Rs. 50-100, Rs.100-200, Rs.200- 500 and mode of substance use.

The type of substance use shows that among the male respondents, less than a third (29.10%) had no response, and only a few (1.59%) used heroin and cough syrup (0.75%) respectively. Less than half of the male respondents (40.30%) used spasmoproxyvon and the remaining, less than a third (28.36%) used parvonspas. Among the female respondents, almost half of them had no response, and less than a third (29.03%) used Spasmoproxyvon and Parvon Spas (21.77%) respectively. None of the female respondents (0%) used heroin as their fourth substance.

**Table 11: Respondents' Drug Use Pattern at 4th Use by Gender**

Sl.No.	Characteristics	Gender		Total N = 258
		Male n = 134	Female n = 124	
<b>I</b>	<b>Type of Substance</b>			
	Heroin	2 (1.49)	0 (0.00)	2 (0.78)
	Cough Syrup	1 (0.75)	1 (0.81)	2 (0.78)
	SpasmoPoxyvon	54 (40.30)	36 (29.03)	90 (34.88)
	Parvon Spas	38 (28.36)	27 (21.77)	65 (25.19)
<b>II</b>	<b>Age Group 4<sup>th</sup> Use</b>			
	Children (9-14 Yrs.)	5 (5.26)	2 (3.13)	7 (4.40)
	Adolescence (14-18 Yrs.)	19 (20.00)	17 (26.56)	36 (22.64)
	Young Adult (18-24 Yrs.)	66 (69.47)	43 (67.19)	109 (68.55)
	Older Adult (24+ Yrs.)	5 (5.26)	2 (3.13)	7 (4.40)
<b>III</b>	<b>Duration of 4<sup>th</sup> Use</b>			
	No Response	39 (29.10)	60 (48.39)	99 (38.37)
	<6 Months	3 (2.24)	0 (0.00)	3 (1.16)
	6- 12 Months	6 (4.48)	3 (2.42)	9 (3.49)
	12-18 Months	1 (0.75)	1 (0.81)	2 (0.78)
	>24 Months	85 (63.43)	60 (48.39)	145 (56.20)
<b>IV</b>	<b>Money Spent on 4<sup>th</sup> Use</b>			
	No Response	39 (29.10)	60 (48.39)	99 (38.37)
	<50 Rs/day	7 (5.22)	5 (4.03)	12 (4.65)
	Rs. 50-100	5 (3.73)	4 (3.23)	9 (3.49)
	Rs. 100-200	82 (61.19)	55 (44.35)	137 (53.10)
	Rs. 200-500	1 (0.75)	0 (0.00)	1 (0.39)
<b>V</b>	<b>Mode of Substance Use</b>			
	No Response	39 (29.10)	60 (48.39)	99 (38.37)
	Oral	1 (0.75)	1 (0.81)	2 (0.78)
	Injections	92 (68.66)	63 (50.81)	155 (60.08)
	Others	2 (1.49)	0 (0.00)	2 (0.78)

Source: Computed

Figures in Parentheses are Percentages

The age group of the respondents shows that the majority of the males (69.47%) and females (67.19%) are young adults. A fifth of the male respondents (20%) are adolescents and a few are children (5.26%) and older adults (5.26%). Among the female respondents, more than a fourth (26.56%) are adolescents, and only a few (3.13%) are children (3.13%) and older adults (3.13%).

The duration of use shows that the majority (63.43%) of the male respondents and the majority (48.39%) of the female respondents use their fourth substance of choice for more than 24 months respectively. Only a few of the male respondents used their fourth substance for less than six months (2.24%), 6-12 months (4.48%), and 12-18 months (0.75%) respectively. This is almost the same in the case of the female respondents as well only a few (2.42%) used for 6-12 months, and 0.81% used their fourth substance for 12-18 months. And none (0%) of the female respondents used their fourth substance for 12-18 less than 6 months.

The daily money spent on the fourth substance shows that the majority of the male respondents and female respondents spent between Rs. 100-200. Less than a few of the male respondents spent less than Rs.50 (5.22%), Rs. 50-100(3.73%), and Rs. 200- 500 (0.75%) respectively. Among the female respondents, a few (4.03 %) and (3.23%) of the female respondents spent less than Rs.50 and between Rs.50-100. None of the female respondents (0%) spent Rs.200-500.

The mode of substance use shows that injection is the major mode of use for both male (68.66%) and female (48.39%) respondents. Less than half of the female respondents (48.39%) have no response while almost a third of the male respondents (29.10%) have no response. Only a few males (1.49%) use another mode of use.

The table shows that more than a third of the total respondents (38.37%) do not use fourth substances. The type of fourth substance choices are heroin, cough syrup and spasmoproxyvon. There is not much difference among the male and female respondents in their age group as young adults are the highest users in both genders.

## 5.2 Conclusion

This chapter discusses the patterns of substance use among substance abusers including the descriptive statistics of patterns of drug use by gender, respondents' drug use pattern at first use by gender, respondents' drug use pattern at second use by gender, respondents' drug use pattern at third use by gender, respondents drug use pattern at fourth use by gender.

The respondents' first use mean age is 12 (11.67) years, second use the respondents' mean age is 15 (14.49) years, in the third 18.79. In the fourth use, the respondents' mean age is 21 (20.74). All the respondents take their first substance orally; a majority of the respondents used their first substance for about 6-12 months. The type of second abuse of substances is alcohol, cannabis, and cough syrup, The age group at second use shows that half (50%) of the male respondents started their second substance while were children while more than half (60.48%) of the female respondents started their second substance while they were children.

The age group of third use shows that more than half (52.24%) of the male respondents started their third substance in their young adulthood while half (50.81%) of the female respondents started their third substance in their young adulthood. The duration of use shows that the majority (88.81%) of the male respondents and the majority (81.45%) of the female respondents use their third substance of choice for more than 24 months respectively.

More than a third of the total respondents about forty (38.37%) per cent do not use fourth substances. The type of fourth substance choices are heroin, cough syrup and spasmoproxyvon. There is no much difference between the male and female respondents in their age group as young adults are the highest users in both genders.

The next chapter focuses on the family functioning of substance abusers.

## CHAPTER-VI

### FAMILY FUNCTIONING OF SUBSTANCE ABUSERS

This chapter discusses the family functioning of substance abusers, there are two sections in this chapter the first section focuses on the family functioning of substance abusers and mainly concentrates on the qualitative study using a case study. The second section consists of the level of family functioning by gender, area and domicile, age and socio-economic status by the level of family functioning, Chi-square test for association among the type of substance, age, duration and money spent at first use and level of family functioning, Chi-square test for association among the type of substance, age, duration and money spent at third use and level of family functioning, Spearman's Inter Correlation Matrix of Family Functioning, Mann-Whitney U test significant difference between the mean rank of gender and area across family functioning.

#### **6.1 Qualitative Discussion (Case Study) on family functioning of substance abusers**

This section focuses on the family functioning of substance abusers. The researcher conducted four case studies with family members of substance abusers to understand and analyse living with substance abusers.

##### **Case Vignette - 1: At the Beginning**

“John underwent a cunning method to become addicted to drugs. There were subtle but significant changes made to looks and demeanour. We were not aware that drug use was the root cause of these behavioural changes for up to two years. Around the age of 17, he began acting obstinate, withdrawing and private, becoming agitated and irritable, developing ‘funny’ eyes and speech that were slurred, disappearing with no trace, missing money and goods, and other behaviours that raised the possibility that drugs were responsible for the observed behavioural changes. He had changed, and I put those changes down to his age, his hormones, and other things. However, he gradually started to disregard anything that was said to

him. Him and his sister Jojo were fighting all the time”, said the respondent whose son is a substance abuser.

“Because we lacked knowledge and expertise, we reacted with complete terror once we realised there was a drug problem. We use family resources to try to tackle the issue on an internal level. Looking back, I believe that we overestimated their own ability to accomplish this and undervalued the extent to which John was able to or desired to break free from narcotics” she said.

“The need to fulfil this need at all costs and the single-minded emphasis on obtaining and taking drugs were incredibly difficult for us to accept. As I watched him transform physically, socially, and emotionally—becoming pale and drawn, unyieldingly combative, and self-obsessed—I felt helpless to stop the tragedy that was starting to play out in our family”, she added.

“Most of the time, we struggled out of our comfort zone, unsure of how to assist him, but hopeful that our position as parents and the strength of our family would enable him to get through it. To try to sway his behaviours, we called on our authority, compassion, and protection. The medicines would typically prevail in the ensuing struggle of wills, making it clear to us just how strong our adversary was.”

She elaborated, “He was completely shut in his room by us. However, he was scaling windows. No matter how long we put him in there, the moment he comes out, he will be doing it. He admits that given the severity of the issue, not even agreeing to being kept inside would stop him from using drugs.”

In a subtle tone of disappointment, she said, “We turned to a doctor for outside assistance. Before the children’s addiction to drugs got seriously established, as other parents of drug-abusing kids have noted, that was the time when we could have been able to help him the most, if there had been any guidance or help for them from us as a family. It simply appeared to get out of hand. If someone had told me from the beginning, I’ve always said. I believe that I might have the opportunity able to take action and put an end to it.”

However, our sense of shame precluded seeking help from outside of our closest family relatives. This circle would exclude even the extended family in the early days. The burden of carrying such a secret had added greatly to the strains felt by our family” she added.

She went on to say, “Our family response was giving concentrate attention upon John, to try to sort it out and bring him safely back into the fold. The realization of the intractability of his problem and our limited capacity to alter its course marked a new understanding that this might be our family situation for the foreseeable future.”

Whilst still holding out hope, and usually too, the offer to help their John to stop using drugs, some level adapt to this new reality by trying to manage and contain the drug-associated damage.

*“The worst thing about drugs for me is the destruction it does to our family and the destruction it does to me. I always say drugs took me to places that I didn’t want to go mentally, physically and spiritually. They’re a killer, even for my family, I think sometimes we’re in the worse place. As a drug addict you feel so powerless, there’s not a thing you can do” – John.*

### **Case Vignette-2: Living with the drug problem**

“It’s like being at the centre of a hurricane to live near to a drug-using son, daughter, or sibling. Our family is being destroyed by my brother’s addiction in an endless spiral. His addiction destroys his family life and causes his marriage to fall apart. His children suffer greatly as a result of the divorce because they are left without their mother. Due to their drug-using son regularly stealing from them, my parents constantly suffer as well,” says the respondent, giving account of her experience living with a substance abusing sibling.

“He would steal from other people in addition to our house, which is highly dishonourable for us. Along with thieving, he also shouts abusively and violently in public, which clearly demonstrates how helpless he is. My family is embarrassed and shamed by this. Despite his outward indications of his drug use, we avoid discussing

it in public and avoid involving other relatives,” she said when asked about how she perceive the family’s experience.

“I never mentioned Ben to anyone. I feel too humiliated. Since I never spoke to anyone, I believe that for all those years, everything just built up inside of me. It is only now that I discuss Ben and his drug abuse to anyone.” she said.

Further, she added, “He starts verbally abusing my parents when they decline to give him money, something he doesn’t mind doing in front of other people. He would never concede ground in a debate. He constantly believes he is right, even when he disagrees with my parents. His temper would eventually flare to the point where he would start screaming and bawling the entire way along the street. He would yell and call my parents derogatory names that I could not believe were coming from him.”

Giving the account of her experience and how it impacts her, she says, “These scenes were all painful and upsetting in addition to being embarrassing. He continually requests money. Always, it’s about the money. Even though he usually accepts payment, the price of his actions was considerably more than could be expressed in terms of cash or other tangible goods. The bigger price was the deterioration of our familial ties, the loss of mutual respect, and the loss of trust.”

“He never comes home to witness the harm his addiction genuinely causes to his own family. He is never present to witness the harm he causes to our family. He avoids seeing that by being outside all the time. He basically doesn’t know,” she added.

*“It always comes down to money. When he envelops me in his arms and says, “I love you mom,” I shudder because I know it is not sincere. I continued to give him money because I was unable to deal with him.” – Mother*



### **Case Vignette-3: Tough Love**

A father of four, out of which, two are avid substance abusers gave account of his experience and says, “I have four sons, two of whom take drugs, and I am a father. I believe that having multiple children with drug problems makes the issue seem more severe. When I would buy new items for their mother, they would immediately vanish. When I knew they had taken anything, they would blindly swear to their mother that they hadn’t. Over and over again, we would engage in the same argument. I sometimes attempt to avoid the house as much as possible when I’m worried out. As parents, my wife and I disagree on how to address the drug issues.”

On dealing with the issue of substance abuse in his family, he said, “My ideal situation is that my wife and I decide on a strategy to address our family issue. But that is not the situation here. Stealing and other issues that come with addiction were wreaking havoc in our home. In nearly every disagreement and fight I had to handle, their mother was defending the two boys’ drug use. She would hide their wrongdoings, protecting them from my anger and the possibility that they would steal anything from the house. I was neglecting the entire family, including the other two sons who never used drugs.”

Noting despair in his tone, he added, “My drug-addled sons are the only thing waiting for me when I get home from work, which is a worse hassle because they weren’t just robbing us; they were also robbing their brothers.”

He reflects on how him and his wife deals with their addict children and says, “My wife and I were unable to communicate because whenever I got furious, I would end up hitting one of them, which would prevent her from saying too much. When we weren’t arguing, we avoided each other like the plague and everything in our lives had become a mess.”

“I mean, that was about it; I wasn’t doing much else. I was contributing money, giving my wife my money and things like that, and because the issue persisted for a long time, our family was forced to adjust to this unfavourable situation. We are a family that has been turned inside out and is at war with itself. I

don't want my other two sons to suffer from the side consequence of not receiving much attention" he adds.

About the prospect of moving forward, he says, "In general, as parents, we are aware of these problems. I was aware that all of this was going on and was juggling it while also dealing with the children. However, there is significant, ongoing disagreement amongst us in how to handle our children's drug use and the associated expenses for the entire family."

*"I never stop thinking about them, and I never went to bed without praying for them. I can't sleep because I keep thinking about what might happen to them if they overdose and are found unresponsive on the streets."*— Brother

#### **Case Vignette- 4: Mothers as mediator**

"I tried to avoid any escalation in conflict by keeping the children's misdeeds from my husband and even the rest of the family since I was uneasy about how my family would react," recalls a mother who has a substance abusing daughter, who is also a mother.

She emphathises, saying, "Once you're a mother, I believe it's really difficult to retract anything you say. Giving up on her would be incredibly difficult. My husband, by and large, just isn't able to handle it. He worries and doesn't sleep. I didn't disclose half of what occurred. He was unaware of my efforts to withhold these things from him."

On dealing with the issue, she recalls, "In order to avoid the start of yet another heated quarrel, I would covertly give her food and cash when she wasn't supposed to be at the house. In order to conceal her theft from my family, I would go outside in search of the things at home she had just taken. Despite the expenses to myself, I think I have more obligations."

She adds, "I believe that there is a tie between mothers and their children that cannot be broken. Without that, my drug-addicted daughter wouldn't be here at all. Sometimes you wish you could cut someone off, but you are unable to do so. If it

were a neighbour or a friend, you could easily say, ‘Go away, I don’t want to see you again.’ You can’t cut it as a mother, so I would frequently try to keep her as near to me as possible in the hopes that it would give me a little power over the situation and give me the chance to help her sort things out or, if possible, end her drug usage, and if I was unable to accomplish that, to keep her safe.”

She concludes, “Evidently, her father is less convinced of the effectiveness of this tactic. In an attempt to stop this harm, he is more likely to bar her from the house. I believe that the differences in our parents’ opinions on how to react tremendously damaged their relationship with us as children. In essence, her dad entered a long period of denial. He would’ve killed her, so I was afraid to inform him.”

*“I made an effort to keep everyone together. I tried to make everyone happy.”*

– Mother

## **6.2 Case Analysis**

To comprehend the challenges of living with someone who abuses drugs in the family, four research studies have been done with respondents ranging in age from 28 to 56. In one case, multiple family members were questioned. The cases are told in first-person, narrative accounts. “At the beginning, living with the drug problem, Tough Love and Mother as mediator” is the title of the case studies. This renaming better fits the story being employed and safeguards the respondents’ identities. Olson, 1982’s Family Adaptability and Cohesion Scale-II (FACES-II) was used as a resource to help guide the concerns that needed to be discussed. The findings of the case study that was conducted are further qualitatively stated in the paragraphs that follow.

According to a mother who spoke in “At the Beginning” about how she discovered her son’s addiction, developing a drug problem is a sneaky process. Small but major modifications were made in demeanour, behaviour, and appearance. For up to two years, they were unaware that drug usage was the cause of these alterations in behaviour. He started acting defiant, withdrawing and secretive, being

easily angry and agitated, having “funny” eyes and slurred words, vanishing without being seen, and missing money and goods—all of these signs added up to raise the impression that drugs were to blame for the observed behaviour changes.

They found it challenging to accept the need to satisfy this need at all costs and focus solely on obtaining and consuming drugs. As I watched him transform physically, socially, and emotionally—becoming pale and drawn, unyieldingly combative, and self-obsessed—I felt helpless to stop the tragedy that was starting to play out in our family.

A sister of a drug user described her experience as “Living with the drug problem” and said that being near a child, sibling, or brother who uses drugs is like being at the centre of a hurricane. Additionally, he claims that his brother’s addiction is destroying his family in an endless circle. His addiction destroys his family life and causes his marriage to fall apart. His children suffer greatly as a result of the divorce because they are left without their mother. Due to their son’s drug usage and ongoing theft from them, his parents continually suffer as well.

He would steal from other people as well as the house, which is quite dishonourable for the family. Along with stealing, he is also a very violent and nasty person who shouts in public, which demonstrates how helpless he is. The family feels ashamed and embarrassed as a result. Despite his public declarations, they avoided engaging with their extended family in any public acknowledgement of his drug use.

In the case study titled “*Tough Love*,” a father of two drug users described how he and their mother disagreed over how to handle the children’s drug usage. In a perfect world, he and their mother would decide on a course of action to address their family issue. But this is not the case with them. Their home was in disarray due to theft and other issues brought on by addiction. She intended to cover up their wrongdoing and protect them from their father’s fury; they would steal from the house. In addition, he acknowledged that he was disregarding the other two sons in the household who did not use drugs.

To prevent further conflict, the mother in the fourth case study, "*Mother as Mediator*," explained how she tried to keep their daughter's offences hidden from her boyfriend and the other members of the family. She also admitted that when she wasn't permitted to visit the residence, she would covertly give their daughter food and money or replace stolen belongings. Because of this, she frequently chose a strategy that kept her kid as near to her as possible in the hopes that it would give her some say over the situation. She intended to solve the problem for her daughter through this enabling; if possible, she wanted to cease their drug usage, but if not, she wanted to keep her safe.

The interviewees acknowledge that they initially experienced rage, trouble falling asleep, nausea, and an inability to carry out daily chores. They also discussed how addiction affects a family's ability to make money, as well as its physical and mental health.

The fact that humour has been employed as a coping method was mentioned. A family member will make an effort to be humorous in the hopes that his or her humour will be noticed and will continue to play this function to maintain peace and harmony in the home.

No of your age, learning that your kids have a problem with addiction can come as a rude awakening, the parents all agreed. It could make parents doubt their capacity to be good parents or their choices. Like their children, addicts' parents frequently hold themselves responsible for the onset of a substance use disorder.

### **6.3 Quantitative Analysis of Family Functioning of Substance Abusers**

This section consists of the descriptive statistics of family functioning of substance abusers level of family functioning by gender, area and domicile, age and socio-economic status by the level of family functioning, Chi-square test for association among the type of substance, age, duration and money spent at first use and level of family functioning, Chi-square test for association among the type of substance, age, duration and money spent at third use and level of family functioning, Spearman's Inter Correlation Matrix of Family Functioning, Mann-

Whitney U test significant difference between the mean rank of gender and area across family functioning.

**Table 12: Family Functioning Mean Score by Gender**

Characteristics	Gender				Total N= 258		
	Male n = 134		Female n = 124		Mean	N	SD
	Mean	SD	Mean	SD			
Cohesion	6.21	2.20	6.73	2.19	6.46	258	2.21
Expressiveness	6.28	2.32	6.56	2.40	6.42	258	2.36
Independence	6.51	4.04	6.97	3.78	6.73	258	3.91
Control	5.78	2.36	6.24	2.36	6.00	258	2.37
Overall Family Functioning	24.79	8.98	26.51	8.95	25.62	258	8.99

Source: Computed

**Table 12** shows the family functioning by gender. Gender is used to describe the characteristics of women and men that are socially constructed. Among the respondent's mean scores, the majority (6.73) in the independence domain which the majority (6.97) is female which is more than male (6.51), and the mean score (6.46) for cohesion also has a majority mean score (6.73) for females than males (6.21). Likewise, the mean score (6.42) for expressiveness has a majority mean score, (6.56) for females more than males (6.28). The mean score (6.00) for distancing which is the mean score (6.24) for females is greater than the male mean score (5.78).

Hence, the table shows that all the domains of Cohesion, expressiveness, independence, and control do not have much difference in their mean score in which the females have better family functioning than males.

**Table 13: Level of Family Functioning by Gender, Area and Domicile**

Level	Gender		Total N = 258
	Male n = 134	Female n = 124	
Low 9 (<= 18)	37 (27.61)	28 (22.58)	65 (25.19)
Moderate (19 - 27)	50 (37.31)	42 (33.87)	92 (35.66)
High (28+)	47 (35.07)	54 (43.55)	101 (39.15)
Overall FF (Binned)	Area		Total N= 258
	Core n = 210	Periphery n =48	
Low 9 (<= 18)	56 (26.67)	9 (18.75)	65 (25.19)
Moderate (19 - 27)	78 (37.14)	14 (29.17)	92 (35.66)
High (28+)	76 (36.19)	25 (52.08)	101 (39.15)
Overall FF (Binned)	Domicile		Total N = 258
	Urban n = 219	Rural n = 39	
Low 9 (<= 18)	58 (26.48)	7 (17.95)	65 (25.19)
Moderate (19 - 27)	76 (34.70)	16 (41.03)	92 (35.66)
High (28+)	85 (38.81)	16 (41.03)	101 (39.15)

Source: Computed

Figures in Parentheses are Percentages

**Table 13** shows the Level of family functioning by Gender, Area and Domicile. The level of family functioning is divided into three categories Low 9 (<=18), moderate (19-27), and high (28+).

Among the respondents, almost half of the female respondents (44.35%) have a high level of family functioning, while more than a third of the male respondents (35.07%) have a high level of family functioning.

More than a third of both the male (37.31%) and female (33.87%) respondents have a moderate level of family functioning. Less than a third of the male (27.61%) and female (22.58%) respondents have a low level of family functioning.

The area of the respondents is divided into core and periphery. The majority of the respondents (52.08%) who live in the periphery have high family functioning while less than a fifth (18.75%) of the respondents living in the same area have low family functioning. Less than a third (29.17%) of the respondents living in the periphery have moderate family functioning while more than a third (37.14%) of the respondents living in the core area have moderate family functioning. More than a third (36.19%) of the respondents who live in the core area have high family functioning while less than a third (26.67%) living in the core have low family functioning.

The domicile of the respondents is classified into two categories urban and rural. The majority of the respondents who live in rural have high (41.03%) and moderate (41.03%) levels of family functioning while less than a fifth (17.95%) of the respondents living in rural domiciles have low family functioning levels. More than a third of the respondents who live in urban domiciles have moderate (34.70%) and high (38.81%) levels of family functioning, while less than a third (25.19%) of the respondents living in urban domiciles have low levels of family functioning.

The table clearly shows that the respondents living in rural domicile and periphery areas have better family functioning. There is not much difference between the level of family functioning between males and females.



**Table 14: Age and Socio-Economic Status by Level of Family Functioning**

Age	Level of Family Functioning			Total N = 258
	Low (<= 18) n = 65	Moderate (19-27) n = 92	High (28+) n = 101	
Children (<14)	1 (1.54)	3 (3.26)	12 (11.88)	16 (15.90)
Youth (14-24 )	24 (36.92)	34 (36.96)	37 (36.63)	45 (36.55)
Adult (24- 40 )	27 (41.54)	33 (35.87)	34 (33.66)	38 (29.15)
Middle Age (>40)	13 (20.00)	22 (23.91)	18 (17.82)	31 (18.40)
Socio Economic Status	Level			Total N = 258
	Low (<= 18)	Moderate (19 - 27)	High(28+)	
AAY	8 (12.31)	12 (13.04)	12 (11.88)	32 (12.40)
BPL	33 (50.77)	45 (48.91)	48 (47.52)	126 (48.84)
APL	24 (36.92)	35 (38.04)	41 (40.59)	100 (38.76)

Source: Computed

Figures in Parentheses are Percentages

**Table 14** shows Age and SES by the level of family functioning the age group of the respondents are classified into 4 categories Children (<14), Youth (14-24), Adults (24-40), and middle age (>40).

Among the respondent's majority of adults have low family functioning; more than a third of the adult respondents have moderate family functioning and a third have high family functioning. The youth respondents have more than a third of the low level (36.92%) of family functioning, moderate level (36.96%) of family functioning and high level (36.63%) of family functioning. A fifth (20.00%) of the middle-aged respondents have a low level of family functioning, less than a fourth (23.91%) of the middle-aged respondents have a moderate level of family functioning while less than a fifth (17.82%) have a high level of family functioning. Among the children, few of the respondents have low (1.54%) and moderate (3.26%) levels of family functioning while more than a tenth (11.88%) has high family functioning.

The socio-economic status shows that the majority of the respondents (50.77%) belonging to the BPL category have low family functioning, while more than a third of the APL family (36.92%) have moderate family functioning and more than a tenth of AAY family (12.31%) have a low level of family functioning. Almost half of the BPL respondents (48.91%) have a moderate level of family function, more than a third of the APL (38.04%) has a moderate level of family functioning and more than a tenth of the AAY respondents (13.04%) have a moderate level of family functioning. Almost half of the BPL (47.52%) and APL (40.59%) respondents have a high level of family functioning, while more than a tenth of the AAY respondents (11.88%) have high family functioning. The table shows that among the adults, age group between 24-40 years of age, the majority of the respondents have low family functioning and half of the BPL respondents have low family functioning.

**Table 15** shows the Chi-square Test for Association among Type of Substance, Age, Duration and Money Spent at First Use and Level of Family Functioning. The type of substance 1 and level of family functioning have been divided into three categories Low, Moderate and High. Among the respondents, almost half (42.39%) of the alcohol users have moderate family functioning, more than a third (36.92%) have a low level of family functioning and a few (5.94%) have high family functioning. Among the respondents, less than a third of the cannabis users have low (30.77%), moderate (23.91%) and high (20.79%) levels of family functioning respectively. Among the dendrite users, a third (33.70%) of the respondents have a moderate level of family functioning less than a third (32.31%) have a low level of family functioning and (31.27%) have a high level of family functioning.

**Table 15 Chi-square test for association among Type of Substance, Age, Duration and Money Spent at First Use and Level of Family Functioning**

Characteristics	Level of Family /functioning			Total N = 258	Chi-square Value	P-Value
	Low n = 65	Moderate n = 92	High n = 101			
<b>Type of Substance</b>						
Alcohol	24 (36.92)	39 (42.39)	6 (5.94)	69 (26.74)	49.210 <sup>a</sup>	.000**
Cannabis	20 (30.77)	22 (23.91)	21 (20.79)	63 (24.42)		
Dendrite	21 (32.31)	31 (33.70)	74 (73.27)	126 (48.84)		
<b>Age at 1<sup>st</sup> Use class</b>						
Children (9-14 Yrs.)	45 (69.23)	67 (72.83)	96 (95.05)	208 (80.62)	22.433 <sup>a</sup>	.000**
Adolescence (14-18 Yrs.)	20 (30.77)	25 (27.17)	5 (4.95)	50 (19.38)		
<b>Duration of 1<sup>st</sup> Use</b>						
<6 Months	17 (26.15)	26 (28.26)	41 (40.59)	84 (32.56)	15.483 <sup>a</sup>	.017**
6- 12 Months	37 (56.92)	55 (59.78)	40 (39.60)	132 (51.16)		
12-18 Months	2 (3.08)	4 (4.35)	12 (11.88)	18 (6.98)		
>24 Months	9 (13.85)	7 (7.61)	8 (7.92)	24 (9.30)		
<b>Money Spent 1<sup>st</sup> Use/day</b>						
<50 Rs/day	53 (81.54)	78 (84.78)	92 (91.09)	223 (86.43)	3.409 <sup>a</sup>	.182
Rs. 50-100	12 (18.46)	14 (15.22)	9 (8.91)	35 (13.57)		

Source: Computed                      Figures in Parentheses are Percentages \*\*P<0.01, \*P<0.05

To find out the relationship between the Type of first substance abuse and the level of family functioning, the following hypothesis has been formulated:

H<sub>0</sub>: There is no relationship between the type of first substance use and the level of family functioning.

H<sub>1</sub>: There is a relationship between the type of first substance abuse and the level of family functioning.

While applying the Chi-square test  $49.210^a$  and P-Value .000 which is significant at  $<0.01$  levels, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between the type of first substance use and the level of family functioning.

Age at first use and level of family functioning has been divided into three categories Low, Moderate and High. Most of the respondents who started their first substance while they were children (9-14 years) have high family functioning (95.05%) while a few of the respondents who started their substance use when they were adolescents (4.95%) have high family functioning. Less than a third of the respondents (30.77%) who started their first substance while they were adolescents (14-18 years) have low family functioning, less than a third (27.17%) of them have moderate family functioning and while a few of the respondents who started their substance use when they are adolescents (4.95%) have high family functioning.

To find out the relationship between Age at first and the level of family functioning, the following hypothesis has been formulated:

$H_0$ : There is no relationship between age at first use and level of family functioning.

$H_1$ : There is a relationship between age at first use and level of family functioning.

While applying the Chi-square test  $22.433^a$  and P-Value .000 which is significant at  $<0.01$  levels, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between age at first use and the level of family functioning.

Duration of first use is classified into four categories  $<6$  months, 6-12 months, 12-18 months,  $>24$  months and the level of family functioning has been divided into three categories Low, Moderate and High.

Among the respondents that have used substances for less than 6 months almost half (40.59%) have a high level of family functioning, less than a third (28.26%) and (26.15%) have a moderate and low level of family functioning respectively. Among the respondents that have used substances for 6-12 months more than half (56.92%) and (59.78%) have a low and moderate level of family functioning respectively, while more than a third (39.60%) have a high level of family functioning. Among the respondents that have used substances for 12-18 months a few (3.08%) and (4.35%) have a low and moderate level of family functioning respectively, while more than a tenth (11.88 %) has a high level of family functioning. Among the respondents that have used substances for more than 24 months a few (7.61%) and (7.92%) have a moderate and high level of family functioning respectively, and more than a tenth (13.85 %) have a low level of family functioning.

To find out the relationship between the duration of first use and the level of family functioning, the following hypothesis has been formulated:

H<sub>0</sub>: There is no relationship between the duration of first use and the level of family functioning.

H<sub>1</sub>: There is a relationship between the duration of first use and the level of family functioning.

While applying the Chi-square test 15.483<sup>a</sup> and P-Value .017 which is significant at <0.01 levels, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between the duration of first use and the level of family functioning.

Daily money spent on first use is classified into two categories <Rs.50/day and Rs 50-100 and the level of family functioning have been divided into three categories Low, Moderate and High.

Among the respondents that spent less than Rs.50/day most of the respondents have high family functioning (91.09%), moderate family functioning (84.78%) and low family functioning (81.54%).

Among the respondents that spent Rs.50-Rs 100/day a few of the respondents have high family functioning (8.91%), less than a sixth have moderate family functioning (15.22%) and more than a sixth (18.46%) have low family functioning.

To find out the relationship between daily money spent on first use and the level of family functioning, the following hypothesis has been formulated:

H<sub>0</sub>: There is no relationship between daily money spent on first use and the level of family functioning.

H<sub>1</sub>: There is a relationship between daily money spent on first use and the level of family functioning.

While applying the Chi-square test 3.409<sup>a</sup> and P-Value .183 which is significant at <0.05 levels, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between the duration of first use and the level of family functioning.

**Table 16** shows the Chi-square test for association among the type of substance, age, duration and money spent at first use and level of family functioning.

Among the respondents with a low level of family functioning, more than half (63.08%) use alcohol and more than a third (36.92%) use spasmoproxyvon. A few of them (4.62%) started their third substance while they were children, more than a third (35.38%), while they were adolescents and a majority (60%), started their third substance while they were young adults.

A few (1.54%) used for 6-12 months and most of the respondents (98.46%) used for more than 24 months while none (0%) used for less than six months, 12-18 months, 18-24 months and respectively. The majority of the respondents with a low level of family functioning (63.08%) use drugs orally while more than a third (36.92%) are injecting drug users. A tenth (10.77%) spent Rs. 50- 100 daily. Less than a third (32.31%), (27.69%) and (29.23%) daily spent <Rs. 50, Rs. 100-200 and Rs. 200-500 respectively.

**Table 16: Chi-square test for association among Type of Substance, Age, Duration and Money Spent at Third Use and Level of Family Functioning**

Characteristics	Level of Family Functioning			Total N = 258	Chi-square	P-Value
	Low n = 65	Moderate n = 92	High n = 101			
<b>Type of Substance</b>						
Alcohol	41 (63.08)	53 (57.61)	95 (94.06)	117 (102.56)	37.246 <sup>a</sup>	.000**
SpasmoPoxyvon	24 (36.92)	39 (42.39)	6 (5.94)	5 -(2.56)		
<b>Age Group 3<sup>rd</sup> Use</b>						
Children (9-14 Yrs.)	3 (4.62)	3 (3.26)	21 (20.79)	27 (10.47)	22.692 <sup>a</sup>	.000**
Adolescence (14-18 Yrs.)	23 (35.38)	34 (36.96)	41 (40.59)	98 (37.98)		
Young Adult (18-24 Yrs.)	39 (60.00)	55 (59.78)	39 (38.61)	133 (51.55)		
<b>Duration of 3<sup>rd</sup> Use</b>						
<6 Months	0 (0.00)	0 (0.00)	9 (8.91)	9 (3.49)	37.046 <sup>a</sup>	.000**
6- 12 Months	1 (1.54)	6 (6.52)	18 (17.82)	25 (9.69)		
12-18 Months	0 (0.00)	0 (0.00)	2 (1.98)	2 (0.78)		
18-24 Months	0 (0.00)	2 (2.17)	0 (0.00)	2 (0.78)		
>24 Months	64 (98.46)	84 (91.30)	72 (71.29)	220 (85.27)		
<b>Mode of substance use</b>						
Oral	41 (63.08)	53 (57.61)	95 (94.06)	189 (73.26)	37.246 <sup>a</sup>	.000**
Injections	24 (36.92)	39 (42.39)	6 (5.94)	69 (26.74)		
<b>Money Spent on 3<sup>rd</sup> Use</b>						
<50 Rs/day	21 (32.31)	25 (27.17)	29 (28.71)	75 (29.07)	12.540 <sup>a</sup>	.051*
Rs. 50-100	7 (10.77)	17 (18.48)	20 (19.80)	44 (17.05)		
Rs. 100-200	18 (27.69)	33 (35.87)	18 (17.82)	69 (26.74)		
Rs. 200-500	19 (29.23)	17 (18.48)	34 (33.66)	70 (27.13)		

Source: Computed

Figures in Parentheses are Percentages \*\*P<0.01, \*P<0.05

Among the respondents with a moderate level of family functioning, more than half (57.61%) use alcohol and more than a third (42.39%) use spasmoproxyvon. A few of them (3.26%) started their third substance while they were children, more than a third (36.96%) while they were adolescents and the majority (59.78%) started their third substance while they were young adults. A few (6.52%), and (2.17%) were used for 6-12 months and 18-24 months respectively. Most of the respondents (91.30%) used for more than 24 months while none (0%) used for less than six months, 12-18 months, respectively. The majority of the respondents with a low level of family functioning (57.61%) use drugs orally while more than a third (42.39%) are injecting drug users. More than a tenth (18.48%) each spent Rs. 50-100 and Rs. 200-500 daily. More than a third (35.87%), daily spent Rs. 100-200.

Among the respondents with a high level of family functioning, the majority (94.06%) use alcohol and a few (5.94%) use spasmoproxyvon. A fifth of them (20.79%) started their third substance while they were children; more than a third (40.59%) while they were adolescents and more than a third (38.61%) started their third substance while they were young adults. A few (8.91%), and (1.98%) use for less than 6 months and 12- 18 months respectively. Less than a fifth (17.82%) use it for 6-12 months. Most of the respondents (71.29%) use it for more than 24 months while none (0%) for 18-24 months. The majority of the respondents with a low level of family functioning (94.06%) use drugs orally while a few (5.94%) are injecting drug users. Less than a third (28.71%) spent less than Rs. 50 daily, less than a fifth (19.80%), (17.82%) spent Rs. 50- 100 and Rs. 100-200 respectively. About a third (33.66%) spent Rs. 200- 500 daily.

To find out the relationship between the type of third substance use and the level of family functioning, the following hypothesis has been formulated:

H<sub>0</sub>: There is no relationship between the type of third substance use and the level of family functioning.

H<sub>1</sub>: There is a relationship between the type of third substance use and the level of family functioning.



While applying the Chi-square test 37.264<sup>a</sup> and P-Value .000 which is significant at <0.01 levels, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between the type of third substance use and the level of family functioning.

To find out the relationship between the age group at third substance use and the level of family functioning, the following hypothesis has been formulated.

H<sub>0</sub>: There is no relationship between the age group at third substance use and the level of family functioning.

H<sub>1</sub>: There is a relationship between the age group at third substance use and the level of family functioning.

While applying the Chi-square test 22.692<sup>a</sup> and P-Value .000 which is significant at <0.01 levels, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between the age group at third substance use and the level of family functioning.

To find out the relationship between the duration of third substance use and the level of family functioning, the following hypothesis has been formulated.

H<sub>0</sub>: There is no relationship between the duration of third substance use and the level of family functioning.

H<sub>1</sub>: There is a relationship between the duration of third substance use and the level of family functioning.

While applying the Chi-square test 37.046<sup>a</sup> and P-Value .000 which is significant at <0.01 levels, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between the duration of third substance use and the level of family functioning.

To find out the relationship between the mode of use of third substance use and the level of family functioning, the following hypothesis has been formulated:

H<sub>0</sub>: There is no relationship between the mode of use on third substance use and the level of family functioning.

H<sub>1</sub>: There is a relationship between the mode of use on third substance use and the level of family functioning.

While applying the Chi-square test 12.540<sup>a</sup> and P-Value .051 which is significant at <0.05 levels, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between the mode of use of third substance use and the level of family functioning.

To find out the relationship between money spent on third substance use and the level of family functioning, the following hypothesis has been formulated.

H<sub>0</sub>: There is no relationship between money spent on third substance use and the level of family functioning.

H<sub>1</sub>: There is a relationship between money spent on third substance use and the level of family functioning.

While applying the Chi-square test 37.246<sup>a</sup> and P-Value .000 which is significant at <0.01 levels, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between money spent on third substance use and the level of family functioning.

**Table 17: Spearman's Inter Correlation Matrix of Family Functioning**

Domains	Cohesion	Expressiveness	Independence	Control	OverallFF
Cohesion	1.000				
Expressiveness	.719**	1.000			
Independence	.585**	.236**	1.000		
Control	.848**	.716**	.618**	1.000	
OverallFF	.909**	.745**	.767**	.933**	1.000

\*\* . Correlation is significant at the 0.01 level (2-tailed).

**Table 17** shows Spearman's Inter correlation matrix of Family Functioning taking into consideration all the domains i.e., cohesion, expressiveness, independence and control.

The correlation coefficient between cohesion and expressiveness domain values is 0.719 which indicates a strong correlation between cohesion and

expressiveness domains. Regarding independence, the P values (0.585 and 0.236) are significant at the 0.01 level which shows that there is a moderate positive correlation between independence and cohesion and a low positive correlation between independence and expressiveness. Regarding control, the P values (0.848, 0.716 and 0.618) are significant at the 0.01 level which also shows that there is a strong correlation between control and cohesion, control and expressiveness, and control and independence.

Regarding overall family functioning, the P-Values (0.909,0.745, 0.767, 0.933) are significant at the 0.01 level, which shows that there is a strong relationship between overall and cohesion, overall and expressiveness, overall and independence, overall and control.

Thus, Spearman’s inter-correlation matrix of family functioning reveals that there is a strong correlation between cohesion and expressiveness, control and cohesion, control and expressiveness, and control and independence. At the same time in the domain of independence, there is a significant relationship between independence and cohesion, independence and expressiveness. The overall family functioning shows that there is a strong positive correlation across the domains.

**Table 18: Mann-Whitney U test Significant Difference between Mean Rank of Gender and Area across Family Functioning**

Domains	Gender n = 258		Z-Value	P-Value
	Male n = 124	Female n = 124		
Cohesion	121.31	138.35	-1.882	.060
Expressiveness	124.95	134.42	-1.046	.295
Independence	126.38	132.87	-.928	.353
Control	122.37	137.20	-1.638	.101
Overall IFF	122.87	136.67	-1.514	.130
	Area n = 258			
	Core n = 210	Periphery n =48	Z Value	P-Value
Cohesion	125.01	149.14	-2.075	<b>.038*</b>
Expressiveness	125.98	144.90	-1.628	.104
Independence	127.60	137.81	-1.138	.255
Control	124.06	153.30	-2.516	<b>.012**</b>
OverallIFF	124.75	150.30	-2.183	<b>.029*</b>

Source: Computed

\*p<0.05

\*\*p<0.01

**Table 18** shows the Mann-Whitney U test significant difference between the mean rank of gender across Family Functioning and the mean rank of area across gender. Gender is an important determining variable in terms of Family Functioning.

Among the respondents' mean rank, in the cohesion domain, the majority (138.05) are female than male (121.31). In the mean rank of gender across family functioning for expressiveness, the majority (134.2) is found in females than males (124.95). The mean rank for independence also has a majority (132.87) for females rather than males (126.38). In the mean rank for control, females (137.20) have the majority score over males (122.87).

Among the overall family functioning domains, the majority mean rank (136.67) is found in female respondents. However, there was no significant difference between the genders. Hence, the table shows that the four domains in ascending order among the male respondents are independence, expressiveness, control and cohesion. And for females, the four domains in ascending order are cohesion, control, expressiveness and independence.

Among the respondents' mean rank, in the cohesion domain, the majority (149.14) is from the periphery rather than the core (125.01). In the mean rank of area across family functioning in the cohesion domain the majority (149.14) is from the periphery than the core (125.01). For expressiveness, the majority (1149.14) is found in the periphery than the core (125.01). The mean rank for independence also has a majority (144.90) for periphery rather than core (125.98). In the mean rank for control, the periphery (153.30) has the majority score over the core (124.06).

Among the overall family functioning domains, the majority mean rank (150.30) is found in periphery respondents. However, there was no significant difference between the areas. Hence, the table shows that the four domains in ascending order among the core respondents are independence, expressiveness, cohesion and control. And for the periphery, the four domains in ascending order are control, cohesion, expressiveness and independence.

## 6.4 Conclusion

This chapter discusses the family functioning of substance abusers, there are two sections in this chapter the first section focuses on the family functioning of substance abusers and mainly concentrates on the qualitative study using a case study. The second section consists of the level of family functioning by gender, area and domicile, age and socio-economic status by the level of family functioning, Chi-square test for association among the type of substance, age, duration and money spent at first use and level of family functioning, Chi-square test for association among the type of substance, age, duration and money spent at third use and level of family functioning, Spearman's Inter Correlation Matrix of Family Functioning, Mann-Whitney U test significant difference between the mean rank of gender and area across family functioning.

The qualitative discussion on family functioning of substance reveals the family found it challenging to accept the need to satisfy this need at all costs and focus solely on obtaining and consuming drugs. The family feels ashamed and embarrassed as a result. Despite their public declarations, they avoided engaging with their extended family in any public acknowledgement of his drug use. The interviewees acknowledged that they initially experienced rage, trouble falling asleep, nausea, and an inability to carry out daily chores. They also discussed how addiction affects a family's ability to make money, as well as its physical and mental health.

The fact that humour has been employed as a coping method was mentioned. A family member will make an effort to be humorous in the hopes that his or her humour will be noticed and will continue to play this function to maintain peace and harmony in the home.

The descriptive statistics show that in all the domains of family functioning-cohesion, expressiveness, independence, and control females have better family functioning than males. Among the respondents, almost half of the female respondents (44.35%) have a high level of family functioning, while more than a third of the male respondents (35.07%) have a high level of family functioning. The

majority of the respondents (52.08%) who live in the periphery have high family functioning while less than a fifth (18.75%) of the respondents living in the same area have low family functioning. The majority of the respondents who live in rural have high (41.03%) and moderate(41.03%) levels of family functioning while less than a fifth (17.95%) of the respondents living in rural domiciles have low family functioning levels.

The respondents living in rural domiciles and periphery areas have better family functioning. The majority of adults have low family functioning more than a third of the adult respondents have moderate family functioning and a third have high family functioning. The table shows that among the adults, age group between 24-40 years of age, the majority of the respondents have low family functioning and half of the BPL respondents have low family functioning.

As per the Chi-square test for association among the type of substance, age, duration and money spent at first use and level of family functioning, it is found that there is a relationship between type of first substance use and level of family functioning, age at first use and level of family functioning duration of first use and level of family functioning, there is a relationship between daily money spent and level of family functioning.

As per the Chi-square test for association among the type of substance, age, duration and money spent at third use and level of family functioning, it is found that there is a relationship between type of third substance use and level of family functioning, age group third substance use and the level of family functioning, duration of third substance use and the level of family functioning, mode of use of third substance use and level of family functioning, money spent on third substance use and level of family functioning.

Spearman's inter-correlation matrix of family functioning reveals that there is a strong correlation between cohesion and expressiveness, control and cohesion, control and expressiveness, and control and independence. At the same time in the domain of independence, there is a significant relationship between independence

and cohesion, independence and expressiveness. The overall family functioning shows that there is a strong positive correlation across the domains.

Among the overall family functioning domains, the majority mean rank (150.30) is found in periphery respondents. However, there was no significant difference between the areas. Hence, the table shows that the four domains in ascending order among the core respondents are independence, expressiveness, cohesion and control. And for the periphery, the four domains in ascending order are control, cohesion, expressiveness and independence.

The Mann-Whitney U test shows the significant difference between the mean rank of gender across family functioning and the mean rank of area across gender. Among the overall family functioning domains, the majority mean rank (150.30) is found in periphery respondents. However, there was no significant difference between the areas. The four domains in ascending order among the core respondents are independence, expressiveness, cohesion and control; and for the periphery, the four domains in ascending order are control, cohesion, expressiveness and independence.

In the mean rank of area across family functioning in the cohesion domain the majority (149.14) is from the periphery than the core (125.01). Among the overall family functioning domains, the majority mean rank (150.30) is found in periphery respondents. However, there was no significant difference between the areas. The four domains in ascending order among the core respondents are independence, expressiveness, cohesion and control, and for the periphery, the four domains in ascending order are control, cohesion, expressiveness and independence.

The next chapter discusses the family resilience of substance abusers.

## **CHAPTER - VII**

### **FAMILY RESILIENCE AND SUBSTANCE ABUSE**

The preceding chapter offered an understanding of the family functioning of substance abusers. This chapter discusses family resilience and substance abuse; there are two sections in this chapter. The first section focuses on the focus group discussion while the second section concentrates on the level of resilience by gender and form of family, the level of resilience by domicile and area, level of resilience by age group, annual family income and level of resilience, Chi-square test for association between family functioning and resilience, Kruskal Wallis test for significant difference among the mean rank of resilience concerning factors of family function.

#### **7.1 Qualitative Discussion (Focus Group Discussion) on Family Resilience and Substance Abuse**

The focus group discussion guide was prepared with the help of the Family Resilience Assessment Scale (FRAS; Tucker, Sixbey 2006). This scale is a multi-dimensional scale tapping into various dimensions of quality of life. The discussion was framed within the context of three factors that indicate their belief systems, organizational patterns and Communication processes.

The discussion was held with a sample of parents, siblings and spouses representing families with substance abusers.

The focus group discussion was conducted with sixteen members of the family. There were nine female and seven male participants whose ages were between 19 years to 53 years old. Three points were discussed on the topic of - belief systems, organizational patterns and communication processes which are described as follows:

During the focus group discussion, sixteen family members participated. Participants ranged in age from 19 to 53 years old, including nine women and seven



men. The following three points—belief systems, organisational patterns, and communication processes—were covered in the discussion:

### **1. Belief Systems**

Family belief systems have an impact on how families view and handle problems. Making sense of adversity, cultivating a positive attitude, and nurturing a feeling of transcendence and spirituality are among the critical belief systems associated with resilience, according to Walsh (1998).

Families of substance abusers have discussed the difficulties they experience as a result of weak bonds and a lack of support during difficult times. They frequently struggle to come together and get through these trying moments as a group. Family members and drug users frequently feel a sense of mistrust for one another. This makes their family's struggles much more difficult and makes it more difficult for them to work together to find a workable solution. It was explained how these stresses on interpersonal relationships, brought on by a lack of honest interaction and an unsupportive atmosphere, make families more susceptible to crises and lead to greater drifts in their interpersonal relationships.

Due to their resentment of the abuser's actions, participants frequently report feeling distant and detached from any activities that would improve their relationships. The shift to dealing with the stressors brought on by the substance abuser is frequently too much for them. It is challenging to concentrate on both the problems at hand as a family and on each individual's particular struggles because each member of the family handles these changes differently. Children of substance-abusing parents sometimes assume adult tasks in the home, which can overburden them with obligations at a young age and cause them to accelerate through the developmental phases of childhood.

The dysfunction and abrupt changes that characterise daily life for many families who are dealing with substance misuse in the family could normalise internal emotional disorders and undesirable mental states like poor self-esteem, impatience, and powerlessness. Family members may experience rushed and

unprocessed feelings as a result of these unforeseen events, leaving them emotionally spent and unable to find order and meaning in some situations. This reduces their capacity for adaptive problem-solving and the development of appropriate coping mechanisms.

Families of substance addicts talked about how these difficulties and issues are tragic in their eyes. They conclude that they are in despair because they feel powerless to solve issues and unable to do so due to a lack of information and resources. Instead of putting up a front to tackle the issues collectively, there is a lot of blaming and accusations among family members.

The debate revealed that the families affected by substance abuse are pessimistic about the likelihood of successful change during trying times. They break down, suffer distress, and frequently suffer from fear of the unpredictability of the consequences. The absence of encouragement and a positive outlook on the situation is due to their lack of interaction and clarity. Each family member feels warped as a result and is unable to make a progressive choice that would benefit both the substance abuser and the family as a whole.

The family is filled with a lot of fear and concern about the future as a result of the abuser's intermittent behavioural adjustments. Dwelling on their lack of success and accepting that they can't change their surroundings limits their potential to find a positive and progressive solution to better their circumstance. Some members consider the possibility of leaving their loved ones and escaping the issues when they feel as though the future and opportunities are dwindling as a result of this fatalistic outlook. This puts the family at a higher probability of experiencing detrimental effects that result in mental health conditions like anxiety, stress, and depression.

It was also mentioned that feelings of alienation and neglect frequently surface in families experiencing such a crisis of substance abuse. Even though religion is deeply ingrained in the lives of most individuals, living with substance misuse can make religious convictions difficult to maintain. Many families frequently wait on spiritual forces with naive trust because they perceive substance

abuse as immoral conduct. The family's once upbeat atmosphere frequently gives way to feelings of worthlessness, humiliation, guilt, and perplexity. People frequently lose hope in a higher power to help them during a crisis and feel abandoned and abandoned by any other form of faith they may have had.

## **2. Organizational Patterns**

The second topic of discussion appears to be organisational patterns, which, by Olson (1989) and Walsh (1998), discuss versatility and cohesion and have been noted as important aspects of family functioning. These authors also noted that adaptability, connection, and use of social and financial assets all have an impact on a family's capacity to function in the face of challenges.

Families suffering from substance misuse made it clear that when the symptoms of addiction cause their surroundings to shift, they find it challenging to adapt. They struggle to preserve stability and continuity in the way the family functions and find it hard to deal with unexpected, unpredictable changes. Their attention is mostly on immediate requirements, which makes it practically impossible for them to have any long-term effective planning because their resistance to change frequently leads to stress and inadequate crisis responses. They feel uneasy making adjustments because they believe the substance user may react negatively out of retaliation or revenge.

The majority of relatives of substance abusers reported avoiding honest and productive dialogue out of bitterness and blame. Individual requirements are frequently ignored, which results in the minimal amount of support being offered. Particularly in households where the parents are substance abusers, family structures and responsibilities are disorganised.

Additionally, it seemed that those who were younger in the family were less involved with them and relied more on other sources of assistance. Younger family members suffer from intense feelings of misunderstanding as a result. As a result, they are more susceptible to peer pressure and run an increased risk of developing behavioural issues and engaging in antisocial activity.

It was clear from the conversation that the parents of substance abusers frequently exhibit contradictory parenting styles; substance abusers frequently grow up with families who are not actively involved in their lives. These parents didn't set up an explicit set of house rules and didn't feel the need to watch over their kids' friends, where they go, or what they do. Due to emotions of abandonment and neglect, this carefree parenting style encourages the kids to seek consolation and comfort from other sources and damages their relationship with their parents.

Poor parental supervision is another common occurrence in families where there is substance abuse. Parents frequently give up on their children's addictions out of fear of retribution or to stop the drug user from bugging them. Many parents would rather comply with their substance-abusing children's demands and get rid of them than engage in verbal exchanges and disagreements that might result in further unpleasant verbal and physical altercations. In some situations, even though some family members firmly refuse, others often cave. This is because there is a lack of consistency and differences in opinions and methods among family members. Such actions typically do more harm than good while trying to address crises.

It is also noteworthy that more people who consume drugs come from families with a single parent than from families with two parents. The majority of families fall into the middle- and lower-income brackets, therefore the financial hardships endured by the families of substance abusers are extremely severe. The parents of these families frequently need to acquire additional sources of money to support their loved ones, leaving them with less time to care for their children and frequently having poor parenting skills.

### **3. Communication Processes**

Walsh (1998) asserts that three communication techniques—clear communication, open emotional expression, and cooperative problem-solving—help families remain resilient during minor setbacks and significant life upheavals.

Families of substance abusers have spoken about how they often struggle with emotional expression and find it difficult to convey their feelings, even to one another. They have little verbal and nonverbal communication, and they have trouble opening up. When discussing their feelings, they frequently show unease and discomfort, and their facial expressions are frequently ambiguous. They are unable to verbally or nonverbally communicate their emotions. Their body language is cold and reserved, and they are very cautious about displaying any form of directness and openness.

One interpretation of this would be that families dealing with substance misuse frequently struggle with open emotional expression, the substance abuser frequently feels misunderstood, and their emotions are frequently viewed negatively owing to mistrust and scepticism on the side of their family members. Members of the family hold back their genuine emotions due to deception and secrecy as well as a lack of empathy, and it requires very little time for them to be open and honest with the abuser.

It was emphasised that these families hardly ever had constructive communication. There is very little room for delivering the intended messages to those around them when verbal contact is frequently substituted by outbursts of fury. Members become confused and their words are frequently misunderstood when group members avoid conflict by failing to communicate constructively and healthily. Family members frequently display explosive rage and reactions, which adds to the tension without resolving the immediate problem. All participants in the transaction experience a fairly unpleasant psychological instability as a result.

Another argument made demonstrates how conflict frequently occurs in families as a result of substance misuse, particularly when there is a lack of good cooperative problem-solving effort. Many family members lack the interventional abilities required to assist and support the substance addict. Since each member has a different perspective on the matter and a different way of responding to crises, the problem is frequently left unresolved until another occurrence occurs and the first issue must be ignored. Rarely do family members make decisions together or solve

problems in a cogent way as a group. Dependent family members frequently lack a voice in decision-making, which forces primary carers to exert control over other family members and circumstances. When this occurs, other family members' opinions on the problems are frequently disregarded, which makes them feel helpless and excluded from the entire process of trying to fix the situation.

## 7.2 Quantitative Analysis on Family Resilience of Substance Abusers

The descriptive statistics on family resilience of substance abusers concentrate on the level of resilience by gender and form of family, the level of resilience by domicile and area, level of resilience by age group, annual family income and level of resilience, Chi-square test for association between family functioning and resilience, Kruskal-Wallis test for significant difference among the mean rank of resilience concerning factors of family function.

**Table 19: Level of Resilience by Gender and Form of Family**

Resilience (Binned)	Gender		Total N = 258
	Male n =134	Female n =124	
Least (26 - 50)	27 (20.15)	23 (18.55)	50 (19.38)
Average (51 - 75)	93 (69.40)	94 (75.81)	187 (72.48)
High (76+)	14 (10.45)	7 (5.65)	21 (8.14)
Resilience (Binned)	Form of Family		Total N = 258
	Stable n = 191	Unstable n = 67	
Least (26 - 50)	34 (17.80)	16 (23.88)	50 (19.38)
Average (51 - 75)	141 (73.82)	46 (68.66)	187 (72.48)
High (76+)	16 (8.38)	5 (7.46)	21 (8.14)

Source: Computed

Figures in Parentheses are Percentages

**Table 19** shows the level of resilience by gender and form of family. Resilience is the process and outcome of successfully adapting to challenging life experiences. The level of resilience is divided into three categories: Least (26-50), Average (51-75) and High (76+). Among the respondents with the least resilience a fifth (20.15%) of them are male and less than a fifth (18.55%) are female. Among the respondents with an average level of resilience, more than half (69.40%) are male and the majority (75.81%) are female. Among the respondents with a high level of resilience, a tenth (10.45%) are male and a few (5.65%) are female.

The form of a family is classified into two categories namely stable and unstable. Among the respondents with the least resilience less than a fifth (17.80%) of them are male and more than a fifth (23.88%) are female. Among the respondents with an average level of resilience majority (73.82%) are male and more than half (68.66%) are female. Among the respondents with a high level of resilience a few (8.38%) are male and a few (7.46%) are female. The above table clearly shows that the majority of the respondents have an average level of family resiliency and more than half of the respondents with an average level of resilience have an unstable family.

**Table 20: Level of Resilience by Domicile and Area**

Resilience (Binned)	Domicile		Total N = 258	Chi-square	P-Value
	Urban	Rural			
Least (26-50)	43 (19.63)	7 (17.95)	50 (19.38)	1.352 <sup>a</sup>	.509
Average (51-75)	160 (73.06)	27 (69.23)	187 (72.48)		
High (76+)	16 (7.31)	5 (12.82)	21 (8.14)		
Resilience (Binned)	Area		Total N = 258	Chi-square	P-Value
	Core n = 210	Periphery n = 48			
Least (26 - 50)	45 (21.43)	5 (10.42)	50 (19.38)	14.232 <sup>a</sup>	.001**
Average (51 - 75)	154 (73.33)	33 (68.75)	187 (72.48)		
High (76+)	11 (5.24)	10 (20.83)	21 (8.14)		

Source: Computed

Figures in Parentheses are Percentages \*\*P<0.01, \*P<0.05

**Table 20** shows the level of resilience by domicile and area. Domicile is divided into two categories namely Urban and rural. The level of resilience is divided into three categories: Least (26 - 50), Average (51 - 75) and High (76+). Among the respondents with the least resilience, less than a fifth (19.63%) of them live in urban and less than a fifth (17.95%) lives in rural. Among the respondents with an average level of resilience, more than half (73.06) of them live in urban and more than half (69.23%) live in rural. Among the respondents with a high level of resilience, a few (7.31%) live in urban and more than a tenth (12.82%) live in rural.

The area is divided into two categories namely urban and rural. Among the respondents with the least resilience less than a fifth (21.43%) of them live in the core and a tenth (10.42%) lives in the periphery. Among the respondents with an average level of resilience, more than half (73.33%) of them live in the core and more than half (68.75%) live in the periphery. Among the respondents with a high level of resilience, a few (5.24%) live in the core and a fifth (20.83%) lives in the periphery.

The above table clearly shows that the majority of the respondents with an average level of family resiliency live in urban domicile and core areas.

**Table 21: Level of Resilience by Age Group**

Resilience (Binned)	Age				Total
	Children (<14)	Youth (14-24)	Adult (24- 40)	Middle Age (>40)	
Least (26-50)	2 (12.50)	18 (18.95)	15 (15.96)	15 (28.30)	50 19.4%
Average (51 - 75)	9 (56.25)	66 (69.47)	75 (79.79)	37 (69.81)	187 72.5%
High (76+)	5 (31.25)	11 (11.58)	4 (4.26)	1 (1.89)	21 8.1%
<b>Total</b>	16 (100.00)	95 (100.00)	94 (100.00)	53 (100.00)	258 100.0%

Source: Computed

Figures in Parentheses are Percentages

**Table 21** shows the level of resilience by age. Age is divided into four categories Children (<14), Youth (14-24) Adults (24- 40), and Middle Age (>40).



The level of resilience is divided into three categories: Least (26 - 50), Average (51 - 75) and High (76+).

Among the respondents with the least resilience more than a tenth (12.50%) of them are children, more than a fifth (18.95%) are youth, less than a fifth (15.96%) are adults and less than a third (28.30%) are middle-aged. Among the respondents with an average level of resilience, more than half (56.25%) are children, more than half (69.47%) are youth, the majority (79.79%) are adults and more than half (69.81%) are middle-aged. Among the respondents with a high level of resilience, more than a third (31.25%) are children, more than a tenth (11.58%) are youth, a few (4.26%) are adults and a few (1.89%) are middle-aged.

The table shows that the majority of the respondents have an average level of family resiliency with more than half belonging to the adult age group. While a few of the middle-aged have high levels of family resilience.

**Table 22** shows the Socio-Economic Status and level of resilience of respondents and the Family income and level of resilience of respondents. The level of resilience is divided into three categories: Least (26-50), Average (51-75) and High (76+).

Socio-economic status is a way of describing people based on their education, income and type of job. It is divided into three categories – AAY, BPL and APL. Among the AAY respondents more than a fifth (21.00%) has the lowest level of family resilience, more than two thirds (71.90%) have the average level of family resilience and a few (6.30%) have a high level of family resilience. Among the BPL families, almost a fifth (17.50%) of the respondents have low family resilience, more than two thirds (72.20%) have average family resilience and less than a fifth (10.30%) have high family resilience. Among the APL families, more than a fifth (21.00%) have low family resilience, more than two thirds (73.00%) have an average level of family resilience and less than a tenth (6.00%) have high family resilience.

**Table 22: Socio Economic Status, Annual Family Income and Level of Resilience of Respondents**

Resilience (Binned)	Socio Economic Status			Total N = 258
	AA n = 32	BPL n = 126	APL n = 100	
Least (26 - 50)	7 (21.90)	22 (17.50)	21 (21.00)	50 (19.40)
Average (51 - 75)	23 (71.90)	91 (72.20)	73 (73.00)	187 (72.50)
High (76+)	2 (6.30)	13 (10.30)	6 (6.00)	21 (8.10)
<b>Family Income in Rs.</b>				
Poor - (<90000)	14 (43.80)	84 (66.70)	32 (32.00)	130 (50.40)
Low - (90000-200000)	0 (0.00)	20 (15.90)	33 (33.00)	53 (20.50)
Middle - (200000-500000)	1 (3.10)	20 (15.90)	35 (35.00)	56 (21.7)
Upper - (500000-1000000)	17 (53.10)	2 (1.60)	0 (0.00)	19 (7.40)

Source: Computed

Figures in Parentheses are percentages

Family income plays an important role in determining family resilience. Annual family income is divided into four categories by binning method: Low- (Rs.<90,000), Lower-middle (Rs.90,000-2,00,000), Upper-Middle (Rs.2,00,000-5,00,000), High (Rs.5,00,000-10,00,000).

Among the AAY respondents less than a fifth (43.80%) belong to poor income category, more than half (53.10%) belong to upper income group and a few (3.10%) belong to middle family income. Among the BPL families, more than two thirds (66.70%) of the respondents belong to poor income category, both less than a fifth (15.90%) belong to low as well as middle income group.

Among the APL families, less than a third (32.00%) belong to poor family income, a third (33.00%) belong to low and more than a third (35.00%) belong to middle income group.

The above table shows that the majority of the respondents have average resilience in which majority of the respondents belong to both APL and BPL social economic status. While in the family income majority of the respondents belong to poor category in which majority of the respondents belong to BBP category with respect of socio economic status.

**Table 23: Chi-square test for association between Family Functioning and Resilience**

Resilience (Binned)	Overall FF (Binned)			Total	Chi-square Value	P-Value
	Low (<=18)	Moderate (19 - 27)	High(28+)			
Least (26 - 50)	11 (16.92)	20 (21.74)	19 (18.81)	50 (19.38)	10.683 <sup>a</sup>	.030*
Average (51 - 75)	51 (78.46)	69 (75.00)	67 (66.34)	187 (72.48)		
High (76+)	3 (4.62)	3 (3.26)	15 (14.85)	21 (8.14)		
Total	65 (100.00)	92 (100.00)	101 (100.00)	258 (100.00)		

Source: Computed Figures in Parentheses are Percentages, \*\*P<0.01, \*P<0.05

**Table 23** shows the Chi-square test for the association between Family Functioning and Resilience. The family resilience and family functioning based on overall scores have been divided into three categories Low, Moderate and High. Among the respondents, the majority (72.48%) have average level of resilience with more than three-fourths (78.40%) have low level of family functioning.

The following hypotheses have been formulated to test the relationship between family functioning and family resilience:

H<sub>0</sub>: There is no relationship between family functioning and family resilience.

H<sub>1</sub>: There is a relationship between family functioning and family resilience.

While applying the Chi-square test 10.683 and a P-Value of 0.30 which is significant at a 0.05 level. Hence, the null hypothesis is rejected and the alternate

hypothesis is accepted. Therefore, there is a relationship between family functioning and family resilience.

**Table 24: Kruskal-Wallis test for significant differences among Mean Rank of Resilience Level Concerning Factors of Family Functioning**

Dimensions	Resilience (Binned)			Chi-square Value	P-Value
	Least	Average	High		
Cohesion	128.06	124.46	177.83	10.210	.006*
Expressiveness	131.87	123.77	174.90	9.423	.009*
Independence	133.62	126.82	143.57	2.017	.365
Control	131.15	123.48	179.19	11.138	.004*
Overall FF	134.56	122.84	176.71	10.528	.005*

Source: Computed      Figures in Parentheses are Percentages, \*\*P<0.01, \*P<0.05

**Table 23** shows the Kruskal-Wallis test for significant differences among the mean rank of resilience level concerning factors of family functioning. The mean rank for the high resilience level is the highest in all the domains, (177.83) in the cohesion domain, expressiveness domain (174.90), independence (143.57), control (179.19) and overall family functioning (176.71).

Among the two resilience levels, the least and average levels of resiliency in the cohesion domain least resiliency level is higher (128.06) than the average resiliency level (124.64) in the expressiveness domain the least resiliency level is higher (131.87) than the average resiliency level (123.77). In the independence domain, the lowest resiliency level is higher (133.62) than the average resiliency level (126.82). In the control domain, the lowest resiliency level is higher (131.15) than the average resiliency level (122.84). In the overall family functioning the least resiliency level is higher (34.56) than the average resiliency level (122.84).

To test the significant difference between mean ranks of resilience level across the domains of family functioning, the following hypotheses have been formulated:

H<sub>0</sub>: There is no significant difference between mean ranks of resilience level across the domains of family functioning.

H<sub>1</sub>: There is a significant difference between mean ranks of resilience level across the domains of family functioning.

Since the P-value is less than 0.01, the null hypothesis is rejected at the 1% level about the significant difference between mean ranks of resilience level across the domains of family functioning. Hence, there is a significant difference between mean ranks of resilience level across the domains of family functions such as cohesion, and control expressiveness. However, there is no significant relationship between the independence domain and family functioning.

### **7.3 Conclusion**

This chapter discusses family resilience and substance abuse; there are two sections in this chapter. The first section focuses on the focus group discussion while the second section concentrates on the level of resilience by gender and form of family, the level of resilience by domicile and area, level of resilience by age group, annual family income and level of resilience, Chi-square test for association between family functioning and resilience, Kruskal Wallis test for significant difference among the mean rank of resilience concerning factors of family function.

In the Focus Group Discussion, the families of substance abusers discussed the difficulties they experience as a result of weak bonds and a lack of support during difficult times. They frequently struggle to come together and get through these trying moments as a group. Family members and drug users frequently feel a sense of mistrust for one another.

This makes their family's struggles much more difficult and makes it more difficult for them to work together to find a workable solution. It was explained how these stresses on interpersonal relationships, brought on by a lack of honest interaction and an unsupportive atmosphere, make families more susceptible to crises and lead to greater drifts in their interpersonal relationships.

Families suffering from substance misuse made it clear that when the symptoms of addiction cause their surroundings to shift, they find it challenging to adapt. They struggle to preserve stability and continuity in the way the family

functions and find it hard to deal with unexpected, unpredictable changes. Their attention is mostly on immediate requirements, which makes it practically impossible for them to have any long-term effective planning because their resistance to change frequently leads to stress and inadequate crisis responses. They feel uneasy making adjustments because they believe the substance user may react negatively out of retaliation or revenge.

They have also spoken about how they often struggle with emotional expression and find it difficult to convey their feelings, even to one another. They have little verbal and nonverbal communication, and they have trouble opening up. When discussing their feelings, they frequently show unease and discomfort, and their facial expressions are frequently ambiguous. They are unable to verbally or nonverbally communicate their emotions. Their body language is cold and reserved, and they are very cautious about displaying any form of directness and openness.

The descriptive statistics on family resilience of substance abusers include a level of resilience by gender, level of resilience by domicile and area, level of resilience by age group, annual family income and level of resilience by respondents' Chi-square test for association between family functioning and resilience, Kruskal-Wallis test for significant difference among the mean rank of resilience level concerning factors of family functioning.

The majority of the respondents have an average level of family resiliency and more than half of the respondents with an average level of resilience have an unstable family. The majority of the respondents with an average level of family resiliency live in urban domicile and core areas. The majority of the respondents have an average level of family resiliency in more than half belong to the adult age group. While a few of the middle-aged have high levels of family resilience. The majority of the respondents with a high level of family resilience belong to BPL families and a majority of the respondents with high family resilience belong to the respondents with low annual family income. As per the Chi-square test 10.683 and a P-value of 0.30 which is significant at a 0.05 level. There is a relationship between family functioning and family resilience.

The Kruskal-Wallis test for significant differences among the mean rank of resilience level concerning factors of family functioning shows that the mean rank for the high resilience level is the highest in all the domains, Since the P-value is less than 0.01, the null hypothesis is rejected at the 1% level about the significant difference between mean ranks of resilience level across the domains of family functioning. There is a significant difference between mean ranks of resilience level across the domains of family functions such as cohesion, and control expressiveness. However, there is no significant relationship between the independence domain and family functioning.

The next chapter discusses on quality of life of substance abusers.

## CHAPTER - VIII

### QUALITY OF LIFE AND SUBSTANCE ABUSERS

This chapter highlights the quality of life mean scores by gender and form of family, respondents' quality of life mean scores by domicile and area, respondents' level of quality of life by gender, domicile and area, Chi-square test for association between level of quality of life by age group, level of quality of life by age group and SES, duration and money spent at first use and level of QOL, type of substance, age, duration and money spent at 3rd use and level of QOL, Chi-square test for association between level of family functioning and quality of life, Chi-square test for association between level of family resilience and quality of life, Spearman's inter-correlation matrix of quality of life, Mann-Whitney U test significant difference between the mean rank of gender, domicile and area across the quality of life, Kruskal-Wallis test for significant difference among the mean rank of age group concerning factors of family functioning and quality of life

#### 8.1 Quantitative Analysis of Quality of Life of substance abusers

This section presents the descriptive statistics of quality of life of substance abusers such as the quality of life mean scores by gender and form of family, respondents' quality of life mean scores by domicile and area, respondents' level of quality of life by gender, domicile and area, Chi-square test for association between level of quality of life by age group, level of quality of life by age group and SES, duration and money spent at first use and level of QOL, type of substance, age, duration and money spent at 3rd use and level of QOL, Chi-square test for association between level of family functioning and quality of life, Chi-square test for association between level of family resilience and quality of life, Spearman's inter-correlation matrix of quality of life, Mann-Whitney U test significant difference between the mean rank of gender, domicile and area across the quality of life, Kruskal-Wallis test for significant difference among the mean rank of age group concerning factors of family functioning and quality of life.



**Table 25: Respondents' Quality of Life Mean Scores by Gender and Form of Family**

Domain	Gender				Total	
	Male		Female			
	Mean	SD	Mean	SD	Mean	SD
Physical	41.34	10.61	40.73	10.602	41.0	10.59
Psychological	60.35	20.85	60.08	21.247	60.2	21.00
Social	47.01	26.48	46.30	27.326	46.7	26.84
Environmental	53.89	11.79	54.49	11.910	54.2	11.83
Overall QoL	79.91	12.05	79.75	12.371	79.8	12.18
Domain	Form of Family				Total	
	Stable		Unstable			
	Mean	SD	Mean	SD	Mean	SD
Physical	40.91	10.56	41.42	10.75	41.04	10.59
Psychological	61.17	20.76	57.52	21.62	60.22	21.00
Social	46.73	26.56	46.52	27.83	46.67	26.84
Environmental	54.48	11.45	53.31	12.91	54.18	11.83
Overall QoL	80.18	11.88	78.84	13.04	79.83	12.18

Source: Computed

**Table 25** shows the respondent's quality of life mean scores by gender and form of family. The quality of life has four domains- Physical, Psychological, Social and Environmental.

Gender is an important determining variable for Quality of Life. Among the respondent's mean scores, the majority of the respondents were found in the psychological domain, in which less than two-thirds were male respondents. There is a difference in standard deviation (20.85) for males (21.247) and females. The mean (53.89) score in the environment domain is for males which is less than for females (54.49). In the physical health domain (41.0) mean score, which two fifth (41.34) mean score is found in males and two-fifths (40.73) in females. In terms of the psychological domain, the mean score (60.35) in males is less than in females (54.49). Thus, the table shows that males have a better quality of life in terms of physical and psychological, and females have a better quality of life in terms of social and environmental, which shows that there is not much difference in the level of quality of life in both genders which is reflected in the overall mean score.

The form of family is an important determining variable for Quality of Life. It is divided into two categories- stable and unstable. Among the respondent's mean scores, the majority of the respondents were found in the psychological domain, in which less than two-thirds were male respondents. There is a difference in standard deviation (20.76) for males (21.62) and females. The mean (54.48) score in the environment domain is males which is more than females (53.31). In the physical health domain (41.04) mean score, which two fifth (40.94) mean score is found in males and two-fifths (41.42) in females. In terms of the psychological domain, the mean score (61.17) in males is less than in females (57.52).

The overall QOL mean score shows that stable families have higher overall QOL than unstable families.

**Table 26: Respondents' Quality of Life Mean Scores by Domicile and Area**

Domain	Domicile				Total	
	Urban		Rural		Mean	SD
	Mean	SD	Mean	SD		
Physical	41.21	10.48	40.11	11.31	41.04	10.59
Psychological	59.99	20.67	61.54	23.03	60.22	21.00
Social	46.69	26.99	46.58	26.33	46.67	26.84
Environmental	54.54	11.99	52.16	10.78	54.18	11.83
Overall QoL	79.97	12.16	79.05	12.39	79.83	12.18
Domain	Area				Total	
	Core		Periphery		Mean	SD
	Mean	SD	Mean	SD		
Physical	41.05	10.74	41.00	10.02	41.04	10.59
Psychological	60.42	21.34	59.38	19.65	60.22	21.00
Social	46.07	26.95	49.31	26.45	46.67	26.84
Environmental	54.36	11.78	53.39	12.14	54.18	11.83
Overall QoL	79.87	12.41	79.67	11.25	79.83	12.18

Source: Computed

**Table 26** shows the respondent's quality of life mean scores by domicile and area. The quality of life has four domains: Physical, Psychological, Social and Environmental.

Domicile is an important determining variable for Quality of Life and it is divided into two categories – rural and urban. Among the respondent's mean scores, the majority of the respondents were found in the psychological domain, in which more than two-thirds were respondents from rural domicile. There is some difference in standard deviation (20.67) for males (23.03) and females. In terms of the physical (41.21), social (46.69) and environmental (54.54) respondents living in urban domiciles have a higher quality of life.

The area is divided into two categories – core-periphery. Among the respondent's mean scores, the majority of the respondents were found in the psychological domain, in which the majority were respondents from the core area. There is some difference in standard deviation (21.34) for males (19.65) and females. In terms of the physical (41.05), social (46.07) and environmental (54.36) respondents living in the core area have a higher quality of life.

Thus the table shows that respondents living in urban domicile and core areas have a better quality of life.

**Table 27** shows the respondents' Level of Quality of Life by Gender, Domicile and Area. The level of QOL is classified into three categories Low ( $\leq 75$ ), Moderate (76-90) and High (91+)

Among the respondents, less than half (45.74%) have a moderate quality of life with less than half (46.27%) male respondents and less than half (45.16%) female respondents. Among the respondents with a low level of quality of life, almost a third (32.09%) are male and a third (33.06%) are female. Less than a third (29%) of males and (27%) of females have a high level of quality of life.

**Table 27: Respondents' Level of Quality of Life by Gender,  
Domicile and Area**

QoL (Binned)	Gender		Total N =258
	Male n = 134	Female n = 124	
Low(<= 75)	43 (32.09)	41 (33.06)	84 (32.56)
Moderate (76 - 90)	62 (46.27)	56 (45.16)	118 (45.74)
High(91+)	29 (21.64)	27 (21.77)	56 (21.71)
QoL (Binned)	Domicile		Total N = 258
	Urban n= 219	Rural n = 39	
Low (<= 75)	69 (31.51)	15 (38.46)	84 (32.56)
Moderate (76 - 90)	102 (46.58)	16 (41.03)	118 (45.74)
High (91+)	48 (21.92)	8 (20.51)	56 (21.71)
QoL (Binned)	Area		Total N = 258
	Core n = 210	Periphery n = 48	
Low (<= 75)	69 (32.86)	15 (31.25)	84 (32.56)
Moderate (76 - 90)	95 (45.24)	23 (47.92)	118 (45.74)
High (91+)	46 (21.90)	10 (20.83)	56 (21.71)

Source: Computed

Figures in Parentheses are Percentages

Domicile is divided into two categories Urban and rural. Among the respondents living in urban domiciles almost half (46.58%) have a moderate quality of life while almost half (41.03%) have a moderate quality of life. More than a third (31.51%) of male respondents have a low quality of life while almost two fifth (38.46%) are female. Among the respondents with a high quality of life, less than a third (21.92%) are male and (20.51%) are female.

The area is divided into two – Core and Periphery. Among the respondents with a moderate level of quality of life half of them are living in the core (45.24%) and periphery (47.92%) respectively. Almost a third of the respondents living in the core (32.86%) and periphery (31.25%) have a low quality of life. Less than a third of the respondents living in the core (21.90%) and periphery (20.83%) have a high quality of life.

The above table shows that the majority of the respondents across gender, domicile and area have a moderate level of quality of life.

**Table 28: Chi-square test for association between Level of Quality of Life by Age Group**

QoL (Binned)	Age (Binned)				Total	Chi-square value	P-Value
	<= 14	15 - 31	32 - 49	50+			
Low	2 (12.50)	43 (36.13)	27 (27.00)	12 (52.17)	84 (32.56)	12.878 <sup>a</sup>	<b>.045*</b>
Moderate	12 (75.00)	49 (41.18)	51 (51.00)	6 (26.09)	118 (45.74)		
High	2 (12.50)	27 (22.69)	22 (22.00)	5 (21.74)	56 (21.71)		
Total	16 (100.00)	119 (100.00)	100 (100.00)	23 (100.00)	258 (100.00)		

Source: Computed      Figures in Parentheses are Percentages      \*\*P<0.01, \*P<0.05

**Table 28** shows the Chi-square test for a relationship between QOL and Age group. The QOL and age group based on overall scores have been divided into three categories Low, Moderate and High. Among the respondents, two-fifths (47.54%) are in a moderate level of QOL with which three-fourths (75.00%) are in the age group 14 years and below. Further, it is also found that less than a third have low levels of quality of life. While less than a third have a high level of quality of life.

The following hypotheses have been formulated to test the relationship between QOL and Age group:

H<sub>0</sub>: There is no relationship between QOL and age group.

H<sub>1</sub>: There is a relationship between QOL and age group.

While applying the Chi-square test 12.878<sup>a</sup> and a P-Value of .045 which is significant at a 0.01 level. Hence, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between QOL and age group.

**Table 29** shows the age group of the respondents are classified into 4 categories Children (<14), Youth (14-24), Adults (24-40), and middle age (>40).

Among the respondents, almost half of the youths (46.43 %) have a low quality of life, more than a third of the adult respondents (39.83%) have a moderate quality of life and more than a fourth (21.43%) of the middle age have low quality of life. The youth respondents have almost a third of a moderate level (36.96%) of quality of life and more than a third (37.50%) high level of quality of life. More than a fourth (20.34%) of the middle-aged respondents have a moderate level of quality of life, and less than a fourth (19.64%) have a high level of quality of life.

**Table 29: Level of Quality of Life by Age Group and SES**

Age in Years	QoL (Binned)			Total N = 258
	Low n = 84	Moderate n =118	High n = 56	
Children (<14)	2 (2.38)	12 (10.17)	2 (3.57)	16 (6.20)
Youth (14-24)	39 (46.43)	35 (29.66)	21 (37.50)	95 (36.82)
Adult (24-40)	25 (29.76)	47 (39.83)	22 (39.29)	94 (36.43)
Middle (>40)	18 (21.43)	24 (20.34)	11 (19.64)	53 (20.54)
<b>SES</b>				
AAY	12 (14.29)	13 (11.02)	7 (12.50)	32 (12.40)
BPL	40 (47.62)	56 (47.46)	30 (53.57)	126 (48.84)
APL	32 (38.10)	49 (41.53)	19 (33.93)	100 (38.76)

Source: Computed

Figures in parentheses are percentages

Among the children, few of the respondents have a low (2.38%) quality of life a tenth (10.17%) have a moderate quality of life and a few (3.57%) have high family functioning.

The socio-economic status shows that more than half (53.57%) of the BPL respondents have a high quality of life while less than half of them have low (47.62) and moderate (47.46%) quality of life. Among the AAY families, less than a fifth (14.29%) have a low level of quality of life, a little more than a tenth (11.02%) have a moderate quality of life and more than a tenth (12.50%) have a high quality of life.

Among the respondents with APL socio-economic status, more than two-fifths (41.53%) have a moderate quality of life while less than two-fifths (38.10%) have a low quality of life and more than a third (33.93%) have a high quality of life.

The above table shows that a few of the children have a low quality of life and almost two-fifths of the adults have a high quality of life. The majority of the BPL respondents have a high quality of life while less than a fifth (14.29%) of the AAY respondents have a low quality of life.

**Table 30: Chi-square test for association between Level of Family Functioning and Quality of Life**

QoL (Binned)	Overall FF (Binned)			Total	Chi-square Value	P-Value
	Low (<= 18)	Moderate (19 - 27)	High (28+)			
Low (<= 75)	17 (26.15)	38 (41.30)	29 (28.71)	84 (32.6%)	13.153	<b>0.011**</b>
Moderate (76 - 90)	25 (38.46)	41 (44.57)	52 (51.49)	118 (45.7%)		
High (91+)	23 (35.38)	13 (14.13)	20 (19.80)	56 (21.7%)		
Total	65	92	101	258		

Source: Computed      Figures in Parentheses are Percentages \*\*P<0.01, \*P<0.05

**Table 30** shows the Chi-square test for a relationship between the level of family functioning QOL. The family functioning and QOL based on overall scores have been divided into three categories Low, Moderate and High. Among the

respondents, two-fifths (45.7%) are in a moderate level of QOL with which more than half (51.49%) are in a high level of family functioning. Further, it is also found that less than a third are in high -levels of quality of life. While less than a third are at a low level of quality of life.

The following hypotheses have been formulated to test the relationship between family functioning and QOL:

H<sub>0</sub>: There is no relationship between family functioning QOL.

H<sub>1</sub>: There is a relationship between family functioning QOL.

While applying the Chi-square test 13.153 and a P-value of .0011 which is significant at a 0.01 level. Hence, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between family functioning and QOL.

**Table 31: Chi-square test for association between Level of Family Resilience and Quality of Life**

Resilience (Binned)	QoL (Binned)			Total	Chi-square value	P-Value
	Low (<= 75)	Moderate (76 - 90)	High (91+)			
Least (26 - 50)	14 (16.67)	23 (19.49)	13 (23.21)	50 (19.38)	2.514 <sup>a</sup>	.642
Average (51 - 75)	62 (73.81)	88 (74.58)	37 (66.07)	187 (72.48)		
High (76+)	8 (9.52)	7 (5.93)	6 (10.71)	21 (8.14)		
Total	84	118	56	258		

Source: Computed Figures in Parentheses are Percentages \*\*P<0.01, \*P<0.05

**Table 31** shows the Chi-square test for a relationship between the level of family resilience and QOL. The family resilience and QOL based on overall scores have been divided into three categories Least, Average and High. Among the respondents, almost three-fourths (72.48%) are in the Average level of family resilience with which the majority (74.58%) are in the moderate level of QOL. Further, it is also found that a few (5.93) are in moderate -levels of quality of life.



The following hypotheses have been formulated to test the relationship between family functioning and QOL:

H<sub>0</sub>: There is no relationship between family resilience and QOL.

H<sub>1</sub>: There is a relationship between family resilience and QOL.

While applying the Chi-square test 2.514<sup>a</sup> and a P-value of .0.642 which is significant at a 0.01 level. Hence, the null hypothesis is rejected and the alternate hypothesis is accepted. Therefore, there is a relationship between family resilience and QOL.

**Table 32: Spearman’s Inter Correlation Matrix of Quality of Life**

<b>DOMAIN</b>	<b>PHY</b>	<b>PSY</b>	<b>SOC</b>	<b>ENV</b>	<b>QOL</b>
Physiological	1.000				
Psychological	.321 <sup>**</sup>	1.000			
Social	.234 <sup>**</sup>	.593 <sup>**</sup>	1.000		
Environmental	.150 <sup>*</sup>	.356 <sup>**</sup>	.403 <sup>**</sup>	1.000	
Overall Quality of Life	.473 <sup>**</sup>	.788 <sup>**</sup>	.803 <sup>**</sup>	.645 <sup>**</sup>	1.000

Source: Computed

\*\*P<0.01, \*P<0.05

**Table 32** shows Spearman’s Inter correlation matrix of Quality of life taking into consideration all the domains i.e., physical, psychological, social and environmental.

The correlation coefficient between psychological and physical domain values is 0.321 which indicates a moderate correlation between psychological and physical domains. Regarding social, the P values (0.234 and 0.593) are significant at the 0.01 level which shows that there is a low positive correlation between social and physical and a moderate positive correlation between social and psychological. Regarding environmental the P values (0.150, 0.356 and 0.403) are significant at 0.01 level which also shows that there is a low correlation between environmental and physical, environmental and psychological, and environmental and social.

Concerning the overall quality of life, the P-values (0.473,0788, 0803, 0.645) are significant at the 0.01 level, which shows that there is a moderate relationship

between overall and physical, and a strong relationship between overall and psychological, overall and social, overall and environmental.

Thus, Spearman’s inter-correlation matrix of quality of life reveals that there is a moderate correlation between psychological and physical domains, a low positive correlation between social and physical and a moderate positive correlation between social and psychological. At the same time in the domain of environment, a low correlation between environmental and physical, environmental and psychological, and environmental and social. The overall quality of life shows that there is a positive correlation across the domains.

**Table 33: Mann-Whitney U test Significant Difference between Mean Rank of Gender, Domicile and Area across Quality of Life.**

Domain	Gender		Z-Value	P-Value
	Male	Female		
Physiological	131.52	127.31	-.458	.647
Psychological	129.62	129.37	-.027	.979
Social	130.54	128.38	-.235	.814
Environmental	127.56	131.60	-.438	.661
Overall Quality of Life	130.07	128.88	-.129	.897
Domain	Domicile		Z-Value	P-Value
	Urban	Rural		
Physiological	131.00	121.09	-.773	.440
Psychological	128.16	137.03	-.687	.492
Social	129.55	129.22	-.026	.979
Environmental	131.47	118.41	-1.014	.310
Overall Quality of Life	130.74	122.53	-.635	.525
Domain	Area		Z-Value	P-Value
	Core	Periphery		
Physiological	129.33	130.24	-.077	.939
Psychological	130.35	125.78	-.384	.701
Social	127.95	136.29	-.705	.481
Environmental	130.56	124.88	-.479	.632
Overall Quality of Life	129.35	130.16	-.068	.946

Source: Computed

\*\*P<0.01, \*P<0.05

**Table 33** shows the Mann-Whitney U test significant difference between the mean rank of gender, domicile and area across the quality of life.

Among the respondents' mean rank, in the physical domain, the majority (131.05) are male than female (127.31). In the mean rank of gender across the quality of life psychological, the majority (129.37) is found in males than females (129.62). The mean rank for social also has a majority (130.54) for males rather than females (128.38). In the mean rank for the environment; males (130.20) have the majority score over females (128.88). Among the overall quality of life domains, the majority mean rank (131.52) is found in male respondents. However, there was no significant difference between the genders. Hence, the table shows that the four domains in ascending order among the male respondents are physical, social, psychological and environmental. And for females, the four domains in ascending order are environmental, psychological, social and physical.

Domicile is divided into two categories- urban and rural. Among the respondents' mean rank, in the physical domain, the majority (131.00) are from urban rather than rural (121.09). In the mean rank of domicile across the quality of life in the psychological domain the majority (137.03) are rural than urban (128.16). For social, the majority (129.55) is found in urban than rural (129.22). The mean rank for the environmental domain also has a majority (131.47) for urban rather than rural (118.41) respondents. Among the overall quality of life domains, the majority mean rank (130.74) is found in urban respondents. However, there was no significant difference between the domiciles. Hence, the table shows that the four domains in ascending order among the urban respondents are environmental, physical, social and psychological. For rural, the four domains in ascending order are psychological, social, physical and environmental.

The area is divided into two categories- core and periphery. Among the respondents' mean rank, in the physical domain, the majority (130.24) is from the periphery than the core (129.33). In the mean rank of area across the quality of life in the psychological domain the majority (130.35) are core than periphery (125.78) respondents. For social, the majority (136.29) is found in the periphery than the core

(127.95). The mean rank for the environmental domain also has a majority of (130.56) for core rather than periphery (124.88) respondents.

Among the overall quality of life domains, the majority mean rank (136.29) is found in periphery respondents. However, there was no significant difference between the areas. Hence, the table shows that the four domains in ascending order among the core respondents are environmental, psychological, physical and social and environmental. And for the periphery, the four domains in ascending order are, social, physical, psychological and environmental.

**Table 34: Kruskal-Wallis test for significant differences among Mean Rank of Age Group Concerning Factors of Family Functioning and Quality of Life**

Family Functioning	Age				Chi-square	P-Value
	Children (<14)	Youth (14-24)	Adult (24- 40)	Middle Age (>40)		
Cohesion	182.38	125.70	129.39	120.55	9.535	.023*
Expressiveness	173.84	132.49	127.09	115.04	8.328	.040*
Independence	153.94	129.41	124.95	130.36	3.666	.300
Control	186.72	128.01	126.71	119.85	11.042	.012**
Overall FF	178.97	129.25	123.86	125.02	8.833	.032*
Quality of Life	Age in years				Chi-square	P-Value
	Children (<14)	Youth (14-24)	Adult (24- 40)	Middle Age (>40)		
Physiological	135.75	124.48	125.38	143.92	2.875	.411
Psychological	133.31	125.80	137.14	121.43	1.896	.594
Social	148.06	120.54	133.88	132.18	2.798	.424
Environmental	129.28	128.28	132.04	127.25	.186	.980
Overall Quality of Life	148.38	118.95	133.59	135.46	3.561	.313

Source: Computed

\*\*P<0.01, \*P<0.05

**Table 34** shows the Kruskal Wallis test for significant differences among the mean rank of age groups across Family Functioning and Quality of life. The mean rank for children (<14) is the highest in all the domains, (186.38) in the cohesion domain, expressiveness domain (173.84), independence (153.94), control (186.72) and overall family functioning (178.97).

To test the significant difference between mean ranks of age groups across the domains of family functioning, the following hypotheses have been formulated:

H<sub>0</sub>: There is no significant difference between the mean ranks of age groups across the domains of family functioning.

H<sub>1</sub>: There is a significant difference between mean ranks of age groups across the domains of family functioning.

Since the P-value is less than 0.01, the null hypothesis is rejected at the 1% level about the significant difference between mean ranks of age groups across the domains of family functioning. Hence, there is a significant difference between mean ranks of age groups across the domains of family functioning such as cohesion expressiveness, control and overall family functioning. However, there is no significant difference between the domain of independence and family functioning.

The mean rank for physical is highest among the middle-aged (143.92), the psychological (137.14) and environmental (132.04) domains are highest for adults; the Social domain is highest (148.06) for children. In physical health, the mean rank for middle age is the highest (143.92), among children (135.75) among adults (125.85) and youth (124.48).

While comparing the age group in the mean rank scores, it was found that the mean ranks of children are social (148.06), physical (135.75), psychological (133.31) and environment (129.28). Similarly, the mean ranks for youth are environment (128.28), psychological (125.80), physical (124.48) and social (120.54). Among adults, the mean rank is highest (137.14) in the psychological domain, social (133.88), environment (132.04), and physical (125.38). Among the overall coping domains, the majority mean rank (148.38) is found among the Children age group.

Among the overall QOL domains, the majority mean rank (148.38) is found among the children age group.

The following hypotheses have been formulated to test the significant difference between mean ranks of age groups across the domains of QOL:

H<sub>0</sub>: There is no significant difference between the mean ranks of age groups across the domains of QOL.

H<sub>1</sub>: There is a significant difference between the mean ranks of age groups across the domains of QOL.

Since the P-value is less than 0.01, the null hypothesis is rejected at a 1% level about the physical health domain and age group. Hence, there is a significant difference between age groups in domains of physical health, psychological, social relationship, environment and total QOL. Based on the mean ranks, respondents belonging to the middle age group have better physical health, and the children age group have better social relationships.

Further, the respondents belonging to the adult age group have better psychological health and a better environment rather than the children, youth and middle age which indicates that the adult age group are more concerned regarding a better environment and the children age group has better overall QOL.

Hence, the table shows that respondents belonging to the young age group have a better quality of life than the middle and old age groups. The mean rank results show that in the domains of QOL, the respondents have significant relationships at a 0.01 level of significance.

## **8.2 Conclusion**

This chapter highlights the quality of life of substance abusers including respondents' mean score by gender and form of family, respondents' mean score by domicile and area, and respondents' level of quality of life by gender, domicile and area.

The overall QOL mean score shows that stable families have higher overall QOL than unstable families. Respondents living in urban domiciles and core areas have a better quality of life. The above table shows that the majority of the respondents across gender, domicile and area have a moderate level of quality of life. Among the respondents, almost three-fourths (72.48%) are in the Average level of

family resilience with which the majority (74.58%) are in the moderate level of QOL.

The Chi-square test is 12.878<sup>a</sup> and has a P-value of .045 which is significant at a 0.01 level and there is a relationship between QOL and age group. There is a relationship between family functioning and QOL.

Spearman's inter-correlation matrix of quality of life reveals that there is a moderate correlation between psychological and physical domains, a low positive correlation between social and physical and a moderate positive correlation between social and psychological. At the same time in the domain of environment, a low correlation between environmental and physical, environmental and psychological, and environmental and social. The overall quality of life shows that there is a positive correlation across the domains.

The Mann-Whitney U test significant difference between the mean rank of gender, domicile and area across the quality of life shows that among the overall quality of life domains, the majority mean rank (131.52) is found in male respondents. However, there was no significant difference between the genders. Hence, the table shows that the four domains in ascending order among the male respondents are physical, social, psychological and environmental. And for females, the four domains in ascending order are environmental, psychological, social and physical.

Among the overall quality of life domains, the majority mean rank (130.74) is found in urban respondents. However, there was no significant difference between the domiciles. Hence, the table shows that the four domains in ascending order among the urban respondents are environmental, physical, social and psychological. For rural, the four domains in ascending order are psychological, social, physical and environmental.

Among the overall quality of life domains, the majority mean rank (136.29) is found in periphery respondents. However, there was no significant difference between the areas. Hence, the table shows that the four domains in ascending order

among the core respondents are environmental, psychological, physical and social and environmental. And for the periphery, the four domains in ascending order are, social, physical, psychological and environmental.

The Kruskal Wallis test for significant differences among the mean rank of age groups across Family functioning and Quality of life shows that while comparing the age group in the mean rank scores, it was found that the mean ranks of children are social (148.06), physical (135.75), psychological (133.31) and environment (129.28). Similarly, the mean ranks for youth are environment (128.28), psychological (125.80), physical (124.48) and social (120.54). Among adults, the mean rank is highest (137.14) in the psychological domain, social (133.88), environment (132.04), and physical (125.38). Among the overall coping domains, the majority mean rank (148.38) is found among the Children age group. Among the overall QOL domains, the majority mean rank (148.38) is found among the children age group.

Based on the mean ranks, respondents belonging to the middle age group have better physical health, and the children age group have better social relationships. The respondents belonging to the adult age group have better psychological health and a better environment rather than the children, youth and middle age which indicates that the adult age group are more concerned regarding a better environment and the children age group has better overall QOL. Respondents belonging to the young age group have a better quality of life than the middle and old age groups.

The next chapter discusses on conclusion of the present study.



## **CHAPTER - IX**

### **CONCLUSION**

The present study mainly discusses the major findings of the research. The research titled “*Family Functioning, Family Resilience and Quality of Life Among Substance Abusers in De-addiction Centres, Aizawl*” is an attempt to study and understand how substance abuse impacts the family functioning, family resilience and the quality of life of substance abusers. The study also tries to understand the relationship between family functioning and substance abuse, family resilience and substance abuse, and quality of life and substance abuse. Information has been sought through both qualitative and quantitative methods.

#### **9.1 Summary**

The whole thesis consists of nine chapters. Among them, the first chapter broadly discusses the general introduction of the study including conceptualization of the term family functioning, family resilience, quality of life, substance abuse, family functioning and substance abuse, family resilience and substance abuse, quality of life and substance abuse, a global scenario of substance abuse, Indian scenario of substance abuse, North-East India Scenario of substance abuse, Mizoram scenario of substance abuse, an overview of the literature and need and significance of the study.

The second chapter discusses the available literature review related to the present study in terms of drugs and their types, substance abuse, its implications and solutions, family and substance abuse, family functioning, family resilience, Quality of Life, national drug policies in India, theories and approaches to family intervention, research gaps.

The third chapter highlights the profile of the study area in detail the State of Mizoram and Aizawl District, De-addiction centres in Aizawl, a statement of the problem, its objectives and hypotheses, pilot study, methodological descriptions of the present study covering the research design, sampling procedure, inclusion criteria, tools used for data collections – structured interview schedule – descriptions

of the scales, interview guide for case studies, a guide for FGD. The sources of data collection, pretesting, data collection, assessments of tools reliability, data processing and analysis, operational definitions, ethical considerations, limitations of the study and the chapter scheme are covered in the present study.

The following are the objectives of the present study:

1. To understand the patterns of substance abuse;
2. To assess the family functioning of substance abusers;
3. To assess the family resilience of substance abusers;
4. To examine the quality of life of substance abusers;
5. To assess the relationship between family functioning, family resilience and quality of life of substance abusers.

The following are the hypotheses of the present study:

1. Greater family resilience, better the quality of life of substance abusers.
2. Better family functioning, better the quality of life of substance abusers.

These two hypotheses are derived from the intuitive sense of the researcher.

The fourth chapter discusses the socio-demographic characteristics of Substance abusers in terms of gender, social characteristics, economic characteristics, familial characteristics, descriptive statistics and parental profile of the respondents.

The fifth chapter discusses the pattern of substance abuse among substance abusers, drug use pattern at first use by gender, drug use pattern at second use by gender, drug use pattern at third use by gender, and drug use pattern at fourth use by gender.

The sixth chapter discusses the family functioning of substance abusers, level of family functioning by gender, area and domicile, age and socio-economic status by the level of family functioning, Chi-square test for association among the type of substance, age, duration and money spent at first use and level of family functioning, Chi-square test for association among the type of substance, age, duration and money

spent at third use and level of family functioning, Spearman's Inter Correlation Matrix of Family Functioning, Mann-Whitney U test significant difference between the mean rank of gender and area across family functioning.

The seventh chapter discusses family resilience and substance abuse, the level of resilience by gender and form of family, the level of resilience by domicile and area, level of resilience by age group, annual family income and level of resilience, Chi-square test for association between family functioning and resilience, Kruskal-Wallis test for significant difference among the mean rank of resilience concerning factors of family function.

The eighth chapter highlights the quality of life mean scores by gender and form of family, respondents' quality of life mean scores by domicile and area, respondents' level of quality of life by gender, domicile and area, Chi-square test for association between level of quality of life by age group, level of quality of life by age group and SES, duration and money spent at first use and level of QOL, type of substance, age, duration and money spent at 3<sup>rd</sup> use and level of QOL, Chi-square test for association between level of family functioning and quality of life, Chi-square test for association between level of family resilience and quality of life, Spearman's Inter-correlation matrix of quality of life, Mann-Whitney U test significant difference between the mean rank of gender, domicile and area across the quality of life, Kruskal-Wallis test for significant difference among the mean rank of age group concerning factors of family functioning and quality of life.

Lastly, the ninth chapter highlights the major findings, discussions, conclusions, suggestions, social work implications and scope for future research.

## **9.2 Socio-Demographic Profile of the Respondents**

The socio-demographic profile of the respondents includes age, marital status, educational qualification, sub-tribe, economic characteristics of the respondents, familial characteristics of the respondents, descriptive statistics of respondents and parental profile of the respondents.

The majority (73.25%) of the respondents belong to the age group between 14- 40 years with which the majorities (83.88%) were female respondents. The mean age of male respondents was higher than that of female respondents by three years. A majority (38.54%) of the respondent's level of education was high-school.

Almost half (48.06%) of the respondents belong to the Lusei sub-tribe, this is because Lusei is the major sub-tribe in Mizo society. The area of the respondents shows that the majority of the respondents (84.88%) were from urban areas, majority of the respondents (81.40%) were from core areas.

Half of them belong to the low-income category (50.39%) and only a few (7.36%) belong to the high income. This indicates that substance abusers in Mizoram families with a high level of income are not as frequent in de-addiction centres as compared to those with low income.

The majority of the families (93.02%) belong to nuclear families and more than half (67.05%) of the respondents belong to medium size family. This is because the nuclear family and medium-sized families are more common in the Mizo society.

This shows that a large family is not common among the Mizo family. There is a huge gap between the amount spent on substances per day as the minimum stands at 20 rupees while the maximum stands at Rs.1000 this reflects that the choice of substances has a huge influence on money spent and the daily dose is a contributing factor.

Parents' education, parents' occupation and parents' income show that a few of the parents are illiterate, most of the parents are privately employed and the majority of the fathers are middle earners while the majority of the mothers are low earners.

### **9.3 Pattern of Substance Use among Substance Abusers**

A pattern of substance use among substance abusers includes the descriptive statistics of patterns of drug use by gender, respondents' drug use pattern at first use by gender, respondents' drug use pattern at second use by gender, respondents' drug

use pattern at third use by gender, respondents' drug use pattern at fourth use by gender

The respondents' first use mean age is 11.5, second use the respondents' mean age is 14.49, in the third 18.79. In the fourth use, the respondents' mean age is 20.74. All the respondents take their first substance orally; a majority of the respondents used their first substance for about 6-12 months. The type of second abuse of substances is alcohol, cannabis, and cough syrup, The age group of second use shows that half (50%) of the male respondents started their second substance while were children while more than half (60.48%) of the female respondents started their second substance while they were children.

The age group of third use shows that more than half (52.24%) of the male respondents started their third substance in their young adulthood while half (50.81%) of the female respondents started their third substance in their young adulthood. The duration of use shows that the majority (88.81%) of the male respondents and the majority (81.45%) of the female respondents use their third substance of choice for more than 24 months respectively.

More than a third of the total respondents (38.37%) do not use fourth substances. The type of fourth substance choices are heroin, cough syrup and spasmoproxyvon. There is not much difference among the male and female respondents in their age group as young adults are the highest users in both genders.

#### **9.4 Family Functioning of Substance Abusers**

The qualitative discussion on family functioning of substance reveals the family found it challenging to accept the need to satisfy this need at all costs and focus solely on obtaining and consuming drugs. The family feels ashamed and embarrassed as a result. Despite their public declarations, they avoided engaging with their extended family in any public acknowledgement of his drug use. The interviewees acknowledged that they initially experienced rage, trouble falling asleep, nausea, and an inability to carry out daily chores. They also discussed how

addiction affects a family's ability to make money, as well as its physical and mental health.

The fact that humour has been employed as a coping method was mentioned. A family member will make an effort to be humorous in the hopes that his or her humour will be noticed and will continue to play this function to maintain peace and harmony in the home.

The descriptive statistic section of this chapter shows that in all the domains of family functioning- Cohesion, expressiveness, independence, and control females have better family functioning than males. Similar and related findings were found in the studies conducted by Coie et al (1993) and Yoshikawa, 1994).

Among the respondents, almost half of the female respondents (44.35%) have a high level of family functioning, while more than a third of the male respondents (35.07%) have a high level of family functioning. The majority of the respondents (52.08%) who live in the periphery have high family functioning while less than a fifth (18.75%) of the respondents living in the same area have low family functioning. The majority of the respondents who live in rural have high (41.03%) and moderate(41.03%) levels of family functioning while less than a fifth (17.95%) of the respondents living in rural domiciles have low family functioning levels.

The respondents living in rural domiciles and periphery areas have better family functioning. The majority of adults have low family functioning more than a third of the adult respondents have moderate family functioning and a third has high family functioning. The table shows that among the adults, age group between 24- 40 years of age, the majority of the respondents have low family functioning and half of the BPL respondents have low family functioning.

As per the Chi-square test for association among the type of substance, age, duration and money spent at first use and level of family functioning, it is found that there is a relationship between type of first substance use and level of family functioning, age at first use and level of family functioning duration of first use and

level of family functioning, there is a relationship between daily money spent and level of family functioning.

As per the Chi-square test for association among the type of substance, age, duration and money spent at third use and level of family functioning, it is found that there is a relationship between type of third substance use and level of family functioning, age group third substance use and the level of family functioning, duration of third substance use and the level of family functioning, mode of use of third substance use and level of family functioning, money spent on third substance use and level of family functioning.

Similar types of findings were found in the relationship between QOL and drug kind or frequency of usage, the results were ambiguous. QOL or its indications were found to be adversely connected with a higher frequency of drug use in several researches (Clifford & Edmundson, 1991).

Spearman's inter-correlation matrix of family functioning reveals that there is a strong correlation between cohesion and expressiveness, control and cohesion, control and expressiveness, and control and independence. At the same time in the domain of independence, there is a significant relationship between independence and cohesion, independence and expressiveness. The overall family functioning shows that there is a strong positive correlation across the domains.

Among the overall family functioning domains, the majority mean rank (150.30) is found in periphery respondents. However, there was no significant difference between the areas. Hence, the table shows that the four domains in ascending order among the core respondents are independence, expressiveness, cohesion and control, and for the periphery, the four domains in ascending order are control, cohesion, expressiveness and independence.

The Mann-Whitney U test shows the significant difference between the mean rank of gender across family functioning and the mean rank of area across gender. That among the overall family functioning domains, the majority mean rank (150.30) is found in periphery respondents. However, there was no significant difference

between the areas. The four domains in ascending order among the core respondents are independence, expressiveness, cohesion and control. And for the periphery, the four domains in ascending order are control, cohesion, expressiveness and independence.

In the mean rank of area across family functioning in the cohesion domain the majority (149.14) is from the periphery than the core (125.01). Among the overall family functioning domains, the majority mean rank (150.30) is found in periphery respondents. However, there was no significant difference between the areas. The four domains in ascending order among the core respondents are independence, expressiveness, cohesion and control. And for the periphery, the four domains in ascending order are control, cohesion, expressiveness and independence.

### **9.5 Family Resilience of Substance Abusers**

In the Focus Group Discussion, the families of substance abusers discussed the difficulties they experience as a result of weak bonds and a lack of support during difficult times. They frequently struggle to come together and get through these trying moments as a group. Family members and drug users frequently feel a sense of mistrust for one another. This makes their family's struggles much more difficult and makes it more difficult for them to work together to find a workable solution. It was explained how these stresses on interpersonal relationships, brought on by a lack of honest interaction and an unsupportive atmosphere, make families more susceptible to crises and lead to greater drifts in their interpersonal relationships.

Families suffering from substance misuse made it clear that when the symptoms of addiction cause their surroundings to shift, they find it challenging to adapt. They struggle to preserve stability and continuity in the way the family functions and find it hard to deal with unexpected, unpredictable changes. Their attention is mostly on immediate requirements, which makes it practically impossible for them to have any long-term effective planning because their resistance to change frequently leads to stress and inadequate crisis responses. They feel uneasy making adjustments because they believe the substance user may react negatively out of retaliation or revenge.



They have also spoken about how they often struggle with emotional expression and find it difficult to convey their feelings, even to one another. They have little verbal and nonverbal communication, and they have trouble opening up. When discussing their feelings, they frequently show unease and discomfort, and their facial expressions are frequently ambiguous. They are unable to verbally or non-verbally communicate their emotions. Their body language is cold and reserved, and they are very cautious about displaying any form of directness and openness.

Family resilience of substance abusers includes a level of resilience by gender, level of resilience by domicile and area, level of resilience by age group, annual family income and level of resilience by respondents' Chi-square test for association between family functioning and resilience, Kruskal-Wallis test for significant difference among the mean rank of resilience level concerning factors of family functioning.

The majority of the respondents have an average level of family resiliency and more than half of the respondents with an average level of resilience have an unstable family. The majority of the respondents with an average level of family resiliency live in urban domicile and core areas. The majority of the respondents have an average level of family resiliency in more than half belong to the adult age group. While a few of the middle-aged have high levels of family resilience. The majority of the respondents with a high level of family resilience belong to BPL families and a majority of the respondents with high family resilience belong to the respondents with low annual family income. As per the Chi-square test 10.683 and a P-value of 0.30 which is significant at a 0.05 level. There is a relationship between family functioning and family resilience.

The Kruskal-Wallis test for significant differences among the mean rank of resilience level concerning factors of family functioning shows that the mean rank for the high resilience level is the highest in all the domains, since the P-value is less than 0.01, the null hypothesis is rejected at the 1% level about the significant difference between mean ranks of resilience level across the domains of family functioning. There is a significant difference between mean ranks of resilience level

across the domains of family functioningsuch as cohesion, and control expressiveness. However, there is no significant relationship between the independence domain and family functioning.

### **9.6 Quality of Life of Substance Abusers**

The quality of life of substance abusers includes respondents' mean score by gender and form of family, respondents' mean score by domicile and area, and respondents' level of quality of life by gender, domicile and area.

The overall QOL mean score shows that stable families have higher overall QOL than unstable families. Respondents living in urban domiciles and core areas have a better quality of life. The above table shows that the majority of the respondents across gender, domicile and area have a moderate level of quality of life. Among the respondents, almost three-fourths (72.48%) are in the average level of family resilience with which the majority (74.58%) are in the moderate level of QOL.

The Chi-square test is 12.878<sup>a</sup> and has a P-value of .045 which is significant at a 0.01 level and there is a relationship between QOL and age group. There is a relationship between family functioning and QOL.

Spearman's inter-correlation matrix of quality of life reveals that there is a moderate correlation between psychological and physical domains, a low positive correlation between social and physical and a moderate positive correlation between social and psychological. At the same time in the domain of environment, a low correlation between environmental and physical, environmental and psychological, and environmental and social. The overall quality of life shows that there is a positive correlation across the domains.

The Mann-Whitney U test significant difference between the mean rank of gender, domicile and area across the quality of life shows that among the overall quality of life domains, the majority mean rank (131.52) is found in male respondents. However, there was no significant difference between the genders. Hence, the table shows that the four domains in ascending order among the male

respondents are physical, social, psychological and environmental, and for females, the four domains in ascending order are environmental, psychological, social and physical.

Among the overall quality of life domains, the majority mean rank (130.74) is found in urban respondents. However, there was no significant difference between the domiciles. Hence, the table shows that the four domains in ascending order among the urban respondents are environmental, physical, social and psychological. For rural, the four domains in ascending order are psychological, social, physical and environmental.

Among the overall quality of life domains, the majority mean rank (136.29) is found in periphery respondents. However, there was no significant difference between the areas. Hence, the table shows that the four domains in ascending order among the core respondents are environmental, psychological, physical and social and environmental. And for the periphery, the four domains in ascending order are, social, physical, psychological and environmental.

The Kruskal-Wallis test for significant differences among the mean rank of age groups across Family functioning and Quality of life shows that while comparing the age group in the mean rank scores, it was found that the mean ranks of children are social (148.06), physical (135.75), psychological (133.31) and environment (129.28). Similarly, the mean ranks for youth are environment (128.28), psychological (125.80), physical (124.48) and social (120.54). Among adults, the mean rank is highest (137.14) in the psychological domain, social (133.88), environment (132.04), and physical (125.38). Among the overall coping domains, the majority mean rank (148.38) is found among the Children age group. Among the overall QOL domains, the majority mean rank (148.38) is found among the children age group.

Based on the mean ranks, respondents belonging to the middle age group have better physical health, and the children age group have better social relationships. The respondents belonging to the adult age group have better psychological health and a better environment rather than the children, youth and

middle age which indicates that the adult age group are more concerned regarding a better environment and the children age group has better overall QOL. Respondents belonging to the young age group have a better quality of life than the middle and old age groups.

### **9.7 Results of Hypothesis testing**

- There is a significant relationship between the type of first substance use and the level of family functioning.
- There is a significant relationship between age at first use and the level of family functioning.
- There is a significant relationship between the duration of first use and the level of family functioning.
- There is a significant relationship between the type of third substance use and the level of family functioning.
- There is a significant relationship between the age group at third substance use and the level of family functioning.
- There is a significant relationship between the duration of third substance use and the level of family functioning.
- There is a significant relationship between the mode of use of third substance use and the level of family functioning.
- There is a significant relationship between money spent on third substance use and the level of family functioning.
- There is a strong correlation between cohesion and expressiveness, control and cohesion, control and expressiveness, and control and independence.
- There is a positive correlation between independence and cohesion, independence and expressiveness.
- There is a strong positive correlation across the domains of family functioning.
- Resilience.
- There is a significant relationship between levels of resilience in terms of core and periphery areas.

- There is a significant association between levels of family functioning and family resilience.
- There is a significant difference between mean ranks of resilience level across the domains of family functioning such as cohesion, and control expressiveness.
- There is a significant relationship between QOL and age group.
- There is a significant association between levels of family functioning and QOL.
- There is no significant association between levels of family resilience and QOL.
- There is a moderate correlation between psychological and physical domains, a low positive correlation between social and physical and a moderate positive correlation between social and psychological.
- As regards, the domain of environment, a low correlation between environmental and physical, environmental and psychological, and environmental and social are found.
- There is a positive correlation across the domains of overall quality of life.
- There is a significant difference between mean ranks of age groups across the domains of family functioning such as cohesion expressiveness, control and overall family functioning.

### **9.8 Suggestion**

- A comprehensive understanding of the role of the family in addictive disorders is needed to help clinicians and families deal with the problem in a better way.
- Acknowledging and understanding the difficulties faced by children of drug-abusing parents to identify protective buffers will be helpful.
- Family should provide freedom, space and stability to enable members to grow and develop in various domains.
- Incorporate family activities that include all families, and begin to build substance abuse prevention into the activities.

- In educational settings teachers can foster resiliency by modelling appropriate behaviours, using a proactive curriculum, and promoting interactions, both individually and with social service delivery systems that are in the best interests of children.
- In-service training is needed to help identify children and parents in high-risk situations, the needs of these families, and intervention strategies based on resiliency models.
- It is essential to expand and modify current methods of assessing the incidence prevalence and impact of substance abuse in terms of the individual substance abuser to capture the family as a whole.
- It is critical to consider the impact a family member may have as a function of multiple roles and their impact on different family function, characteristics and how substance abuse affects the roles and responsibilities associated with each of these roles.
- The qualities of life of the substance abuser have to be enhanced because the resilience level does not influence the domain of QOL through conducting regular Yoga, prayer and meditation techniques that could be introduced in the centre and other stress-free activities.
- Understanding family involvement in recovery efforts along a continuum based on the substance abusers' level of motivation will take developmental factors into account.
- Professional counsellors should be appointed in de-addiction centres to improve the services and treatments in the centres. So that family therapy and therapeutic services will be available. Further, social work methods like casework, group work and community organisation can be conducted and promoted in the de-addiction centres for healthy functioning to facilitate and support better family functioning and family resilience.
- Faith-based Based Organizations (FBOs) working for substance abusers needs professional social workers. Since the systematic understanding of substance abusers and their families is crucial for the recovery process.

- Family Counselling Centres (FCC), educational institutions and youth civil societies like YMA, MSU, MZP etc. should create more awareness towards not only substance abuse but also its impact on the family as a whole.
- Policy should be taken to appoint professional social workers in government-aided Centres through the Ministry of Social Justice and Empowerment.
- Strategies to cope with substance abuse must be multifaceted and viewed as lifelong processes to maximize the wellness of individuals and family systems.

### **9.8.1 Suggestions for Social Workers**

- The purpose of the study is to identify the social work intervention. From the findings, the researcher can link that there is scope for social work intervention in the context of the present study; social workers can intervene in the following manner:
- A social worker is a member of the multidisciplinary team who can serve as a support to substance abusers and their families.
- The social worker would facilitate the substance abuser and listen to their feelings, thoughts, and reactions to their substance-abusing life and talk to them about their worries and concerns.
- Psychiatric social workers and medical social workers could offer counselling services in the de-addiction centre, drop-in centres and community.
- The social worker could teach anger management, and relaxation techniques to help to reduce stress or anxiety or other fears associated with substance abuse.
- The social worker could also provide emotional support, to strengthen the family functioning, family resilience and quality of life of substance abusers.
- The social worker could advocate the importance of including families in the treatment of substance abusers.
- The social worker could mediate between substance abusers and their families to help them understand each other better.

- The social worker could do more research on family functioning and substance abuse, family resilience and substance abuse, quality of life and substance abuse.
- To increase the understanding and the development of more effective interventions, more research needs to focus on the impact of substance abuse in families over time, and not just during isolated contact with treatment providers as a family is dynamic and ever-changing with time.

### **9.9 Implication for Social Work Practice**

Social work is a profession, only more than eight decades old in India. It has its philosophies and principles, knowledge and values, methods, skills and techniques to be practised or intervened by the individuals, groups and communities, those who have encountered challenges in society. Through these social work processes, the clients or the people realize the problems encountered and work out the modalities in such a way that the potential and resources are utilized to remove the cause deal with the symptoms and reduce the magnitude of the problem. In this area there is enough scope to practice the methods of social work such as the primary methods of working with individuals, working with groups, working with communities and the secondary methods namely, social action, social welfare administration and social research.

The primary methods of social work have wider implications for social work to provide counselling on a one-on-one basis; group work can be conducted for the different age groups in the hospital setting, especially for the substance abusers and their families at the micro-level of interventions.

The community organisation method also facilitates the social workers to do meso/mezzo level of intervention in the communities with the help of civil society organisations like Women's Association, Youth Associations and elderly associations which are available in the community by which the social workers play a vital role in the prevention, and awareness generation about substance abuse.



In the secondary social work methods, there is high scope for social work research since there is a dearth of empirical studies on the families of substance abusers and their quality of life.

The present study provides a comprehensive understanding knowledge that familiarises the social worker with family functioning, family resilience and QOL of substance abusers. Subsequently, the social work fraternity must delve into the relationship between family and substance abuse. Taking into consideration the magnitude of the challenges faced by substance abusers and their families, the Government must bring out a separate programme and policy for addressing the issue, so the present study suggests National Programme for Prevention and Control of Substance Abuse could be operated in each state with help of Ministry of Social Welfare.

#### **9.10 Scope for future research**

From the deliberation of the present study, the researcher can explore the scope of future research. Therefore, the scope for future research has been suggested in the following areas:

- There is a wide scope in areas such as community studies, a comparative study of rural and urban where rural communities and urban communities can be selected for the study.
- Social work research could be focused on an empirical understanding of the psychosocial experiences for dealing with the challenges of substance abusers and their families.
- The families of substance abusers are very important to have an in-depth understanding of the challenges faced by substance abusers. There is a scope for future research among the families of Substance abusers to explore the impact on the family as well as the issues and challenges faced by substance abusers across India.
- In future research, there is scope for an in-depth study on the lifestyle of substance abusers by studying the family functioning, resilience and quality of life of substance abusers in the de-addiction centres in northeast India.

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## Consent to Participate in a Research Study

**Study Title: Family functioning, family resilience and quality of life among substance abusers in de- addiction centres in Aizawl, Mizoram.**

Research Scholar  
Esther Lalrinhlui Ralte  
Ph.D Scholar  
Department of Social Work  
Mizoram University

Research Supervisor  
Prof. C. Devendiran  
Department of Social Work  
Mizoram University

*Sir/Madam,*

I, Esther Lalrinhlui Ralte, Ph.D Scholar, Department of Social Work, Mizoram University, am conducting a research on **“Family functioning, family resilience and quality of life among substance abusers in de- addiction centres of Aizawl, Mizoram”**, in order to have an understanding of the lived experiences of the individual or family members that are living with substance abusers in their family

The study will be confidential and will not reveal your identity. The study/interview reports will be presented in my thesis. There will be no financial benefits provided to you for this study.

If you consent to participate in this study please give your signature below.

\_\_\_\_\_  
(Signature)

Thank you.

*\*if consented, please provide contact information (phone number)*





# FAMILY FUNCTIONING, FAMILY RESILIENCE AND QUALITY OF LIFE AMONG SUBSTANCE ABUSERS IN DE-ADDICTION CENTRES IN MIZORAM

Research scholar,  
Esther Lalrinhlui Ralte,  
Department of Social Work,  
Mizoram University.

Research Supervisor,  
Prof. C. Devendiran,  
Department of Social Work,  
Mizoram University.

## Interview Schedule

(Confidential and for research purpose only)

Schedule No: \_\_\_\_\_

Date: \_\_\_\_\_

Investigator: \_\_\_\_\_

### I. Profile of the respondents: Please tick (✓) in the box

Sl. No.	Characteristics	
1.	Name	
2.	Age	_____ Years
3.	Gender	1. Male <input type="checkbox"/> 2. Female <input type="checkbox"/>
4.	Marital Status	1. Married <input type="checkbox"/> 2. Unmarried <input type="checkbox"/> 3. Separated <input type="checkbox"/> 4. Divorced <input type="checkbox"/>
5.	Domicile	1. Urban <input type="checkbox"/> 2. Rural <input type="checkbox"/>
6.	Area	1. Core <input type="checkbox"/> 2. Periphery <input type="checkbox"/>
7.	Sub-tribe	1. Lusei <input type="checkbox"/> 2. Ralte <input type="checkbox"/> 3. Hmar <input type="checkbox"/> 4. Paite <input type="checkbox"/> 5. Pawi <input type="checkbox"/> 6. Any other (specify): _____
8.	Educational Qualification	_____ standard/class.
9.	Schooling	1. Inside Mizoram <input type="checkbox"/> 2. Outside Mizoram <input type="checkbox"/> 3. Specify location: _____
10.	Occupation	1. Unemployed <input type="checkbox"/> 2. Private - employed <input type="checkbox"/> 3. Govt. employee <input type="checkbox"/> 4. Other <input type="checkbox"/>
11.	Type of family	1. Nuclear <input type="checkbox"/> 2. Joint <input type="checkbox"/>
12.	Form of family	1. Stable <input type="checkbox"/> 2. Unstable <input type="checkbox"/> 3. Reconstituted <input type="checkbox"/>
13.	Size of family	_____ Nos.
14.	No. of siblings	_____ Nos.
15.	Socio-economic category	1. AAY <input type="checkbox"/> 2. BPL <input type="checkbox"/> 3. APL <input type="checkbox"/>

16.	Income of the family	Amount _____ per year
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**II. Family Background: Kindly furnish the detail**

S/n	Name	Relationship with respondent	Sex	Age	Ednal. Qual.	Occupation	Monthly Income	Use of Substance
a)								
b)								
c)								
d)								
e)								
f)								

**III. Pattern of Substance Use: Kindly furnish the detail**

S/No	Type(s) of Substance Use	Age at first use	Duration (months/year)	Frequency (Hrs.) per day	Qty. per day	Amount spent per day (in Rs.)

**IV. Factors causing respondent's drug abuse: Please tick (✓) in the box, you can tick (✓) more than one answer.**

1. Boredom       2. Poverty       3. Depression       4. Family Problem
5. Relationship at home       6. Increased availability of drug at low price       7. Lack of job
8. Economic Frustration       9. Lack of proper interest in education
10. To escape problems at home       11. Lack of drug education in family and educational setting

**IV. Family Resilience: Please read and assess your feelings and tick(✓) on the numbers.**

The Rating scale is as follows:

- 0 – Not true at all  
 1 – Rarely true  
 2 – Sometimes true  
 3 – Often true  
 4 – True nearly all of the time

The scale is rated based on how the subject has felt over the past month.

Sl. No.	Description	0	1	2	3	4
1	Our family is flexible					
2	Our family relationship is intimate					
3	We believe in higher power					
4	Our ability to cope with challenges is strong					
5	A favourable outcome brings assurance					
6	We seek laughter in every situation					
7	Surviving tension fortifies our family					
8	We recover after facing difficulties					
9	Eventually all things fall into place					
10	We try our best in everything					
11	You can reach your target					
12	We still try even when it does not look promising					
13	We know where to reach out for support					
14	Stress does not disturb our focus					
15	Choose to guide in overcoming difficulties					
16	Not dismayed by lack of success					
17	Consider of self as courageous					
18	Make hard conclusion					
19	Can handle uncomfortable perception					
20	Act on a feeling with no proof					
21	Powerful intention to accomplish					
22	Confidently moving forward with own goals					
23	Step outside of comfort zone for new task					
24	Does not allow difficulties to stop					

25	Proud feeling of having done something difficult					
----	--	--	--	--	--	--

**V. Family Functioning: Please tick (✓) on the options below that gives the best answer for each question**

Sl. No.	Statement	True	False
1	Family members really help and support one another		
2	Family members often keep their feelings to themselves		
3	Family members are rarely ordered around		
4	We often seem to be killing time at home		
5	We say anything we want to around home		
6	There are very few rules to follow in our family		
7	We put a lot of energy into what we do at home		
8	It is hard to blow off steam at home without upsetting somebody		
9	There is one family member who makes most of the decisions		
10	There is a feeling of togetherness in our family		
11	We tell each other about our personal problems		
12	There are set ways of doing things at home		
13	We rarely volunteer when something has to be done at home		
14	If we feel like doing something on the spur of the moment we often just pick up and go		
15	There is a strong emphasis on following rules in our family		
16	Family members really back each other up		
17	Someone usually gets upset if you complain in our family		
18	Everyone has an equal say in family decisions		
19	There is very little group spirit in our family		
20	Money and paying bills is openly talked about in our family		
21	We can do whatever we want to in our family		
22	We really get along well with each other		
23	We are usually careful about what we say to each other		
24	Rules are pretty inflexible in our household		
25	There is plenty of time and attention for everyone in our family		
26	There are a lot of spontaneous discussions in our family		
27	You can't get away with much in our family		

28	We don't do things on our own very often in our family		
29	In our family, we are strongly encouraged to be independent		
30	We think for ourselves in our family		
31	We come and go as we want to do in our family		
32	There is very little privacy in our family		
33	Family members almost always rely on themselves when a problem comes up		
34	Family members strongly encourage each other to stand up for their rights		
35	It is hard to be by yourself without hurting someone's feelings in our household		
36	We are not really encouraged to speak up for ourselves in our family		

## VI. Quality of Life

The following questions ask how you feel about your quality of life, health, or other areas of your life. **Please choose and circle the answer that appears most appropriate.**

		Very Poor	Poor	Neither poor nor good	Good	Very good
1.	How would you rate your quality of life?	1	2	3	4	5

		Very Dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2.	How would you rate your quality of life?	1	2	3	4	5

The following questions ask about how much you have experienced certain things:

		Not at all	A little	A moderate amount	Very much	An extreme amount
3.	To what extent do you feel that physical pain prevents you from doing what you need to do?	5	4	3	2	1
4.	How much do you need any medical treatment to function in your daily life?	5	4	3	2	1
5.	How much do you enjoy life?	1	2	3	4	5
6.	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A Little	A moderate amount	Very much	Extremely
7.	How well are you able to concentrate?	1	2	3	4	5

8.	How safe do you feel in your daily life?	1	2	3	4	5
9.	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things.

		Not at all	A Little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	1	2	3	4	5
11.	Are you able to accept your bodily appearance?	1	2	3	4	5
12.	Have you enough money to meet your needs?	1	2	3	4	5
13.	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15.	How well are you able to get around?	1	2	3	4	5

		Very Dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16.	How satisfied are you with your sleep?	1	2	3	4	5
17.	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18.	How satisfied are you with your capacity for work?	1	2	3	4	5
19.	How satisfied are you with yourself?	1	2	3	4	5
20.	How satisfied are you with your personal relationships?	1	2	3	4	5
21.	How satisfied are you with your sex life?	1	2	3	4	5
22.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24.	How satisfied are you with your access to health services?	1	2	3	4	5

25.	How satisfied are you with your transport?	1	2	3	4	5
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The following question refers to how often you have felt or experienced certain things.

		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	5	4	3	2	1

**FAMILY FUNCTIONING, FAMILY RESILIENCE AND QUALITY OF LIFE AMONG  
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Prof. C. Devendiran  
Department of Social Work  
Mizoram University**

**INTERVIEW SCHEDULE**

**I. Profile of the respondents**

Sl. No.	Characteristics	
1.	Hming	TNT
2.	Kum	_____
3.	Mipa/ Hmeichhia	1. Mipa 1 <input type="checkbox"/> 2. Hmeichhia <input type="checkbox"/> 2
4.	Nupui/Pasal	1. Nei <input type="checkbox"/> 2. La nei lo <input type="checkbox"/> 3. Tlan <input type="checkbox"/> 4. Inthen <input type="checkbox"/> 5. In thihsan <input type="checkbox"/>
5.	Khua	1. Khawpui <input type="checkbox"/> 2. Thingtlang
6.	Awmna hmun	1. Khawchhung <input type="checkbox"/> 2. Khawpawn <input type="checkbox"/>
7.	Hnam	1. Lushai <input type="checkbox"/> 2. Ralte <input type="checkbox"/> 3. Hmar <input type="checkbox"/> 4. Paite <input type="checkbox"/> 5. Pawi <input type="checkbox"/> 6. A dang a nih chuan (hetah hian ziak rawh): _____
8.	Zir san lam	Pawl _____
9.	School kal na	1. Mizoram chhung <input type="checkbox"/> 2. Mizoram Pawn <input type="checkbox"/> 3. A hmun ziak rawh: _____
10.	Hnathawh	1. Hnathawh nei lo <input type="checkbox"/> 2. Lo nei tu <input type="checkbox"/> 3. Sorkar Hnathawk <input type="checkbox"/> 4. Mahni hna thawk <input type="checkbox"/> 5. Hna dang I thawh chuan hetah hian ziak rawh: _____
11.	Chenpuite	1. Nu leh pa , unau te nena cheng <input type="checkbox"/> 2. Nu leh pa unau bakah midang la awm <input type="checkbox"/>
12.	Chhungkaw awm dan	1. Ngialnghet <input type="checkbox"/> 2. Ngialnghet lo <input type="checkbox"/> 3. Insuihkhawm leh tawh <input type="checkbox"/>
13.	Chhungkaw member awm zat	_____
14.	Unau neih zat	_____
15.	Chhungkaw khawsakna	1. AAY <input type="checkbox"/> 2. BPL <input type="checkbox"/> 3. APL <input type="checkbox"/>



<b>16.</b>	Thla khata Chhungkaw sum lakluhzat	Rs: _____
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**II. Chhungkaw chanchin:**

SI/ no	Hming	Inlaichinna	M/F	kum	Zirna	Hnathawh	Thla hlawh	Ruihtheihthil tih
1	A							
2	B							
3	C							
4	D							
5	E							
6	F							
7	G							
8	H							
9	I							
	J							

10								
11	K							

**III. Ruihtheihthil khawih dan**

S/No	Ruihhlo khawih tawh	Kum engzat I nih in nge I tih tan	Eng hun chhung nge I tih tawh	Nikhata I dose zat ziak rawh	A leina atan nitin engzat nge pawisa I sen ang
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

**IV. Ruihhlo khawih chhan**

1. Nin vang       2. Retheihna       3. Rilru lam harsatna       4. Chhungkaw harsatna
5. Inchung hreawm       6. Ruihhlo tlawm deuha hmuh vang       7. Hna neihloh vang
8. Sum leh paia harsatna vang       9. Zirnaa tui loh vang
10. Chhungkaw buaina theihnghilh nan       11. Inchungka ruihhlo khawih pawizia inzirtir loh vang

12. Schoola ruihho khawih pawih zia zirtir loh vang

13. Tihchhin chak vang

V. Thla khat chhunga I dinhmun hriatna .A dik ber zawnah thai rawh

1	Ka dinhmun a zirin ka insiam rem ve mai zel	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
2	Ka in laichinna neih te hi a nghet tha hlawm khawp mai	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
3	A chang chuan Pathian chauhin min pui thei niin ka hre thin	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
4	Engpawh tawh ila ka tuar chhuak ve mai thei zel	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
5	Ka hun kal tawha hlawhtlinna ka neih te khan thil harsa ka hma chhawn dawnin mahni inrintawkna min pe	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
6	Eng thil ah pawh a hlimawm/nuihzatthlak lai hi ka hmu thei zel	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
7	Harsatna ka tawn himka thatpui/min siam puitling	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
8	Damlohna emaw harsatna ka tawh pawh ngai ka awh leh vat thei zel	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
9	Engpawh hi chhan nei veka thleng a ni	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
10	Eng thilah pawh theitawp ka chhuah thin	Diklo hulhual	Dik zeuh	A changin	A tamzawkah	Dik reng

			zeuh		a dik	
11	Ka tum chu ka hlawhtling ngei thin	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
12	Beiseitur awm lo anga a lan chang pawn ka beidawng duh ngai lo	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
13	Harsatna ka tawh chuan min pui thei tu tur ka hre nual mai	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
14	Boruak sosang deuhah pawh ngaihtuahna fim ka hmang thei, a chia mai mai lo	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
15	Buaina chinfel ngai a awm in a hmahruaitu nih ka duh thin	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
16	Hlawhchhamna in min ti bedawng ve mai ngai lo	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
17	Mi tuarchhel tak niin ka inhria	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
18	Duhthlanna harsa tak ka siam thei	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
19	Rilru nuamlo deuh/ rilru natna tur tmzawkte chu ka palzam mai thei	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
20	Ka ngaihdan tlang takin ka kalpui thin	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
21	Tum ruh tak ka ni	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
22	Ka nun dan hi ka in thunun thei	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
23	Harsatna hmachhawn hi nuam ka ti	Diklo	Dik	A	A	Dik

		hulhual	zeuh zeuh	changin	tamzawkah a dik	reng
24	Ka tum ram thleng turin theihtawp ka chhuah thin	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng
25	Hlawhtlinna ka neih hi chuan ka intitheh hle thin	Diklo hulhual	Dik zeuh zeuh	A changin	A tamzawkah a dik	Dik reng

## VI. Chhungkaw chanchin inhriatna

Sl. No.	Sawifiahna	Dik	Diklo
1	Chhungkaw in tawiawm/ intanpui tha tak kan ni		
2	Kan rilru put hmang sawi chhuak ngai manglo chhungkua kan ni		
3	Kan chhungkua hi thu pe takin kan in tir kual ngai lo		
4	Ina aw mho mai mai nuam kan ti		
5	Inah chuan ka duh zawg kan sawi bawrh bawrh mai thin		
6	Dan leh dun zawm tur vak pawh kan nei lo		
7	Inchhungah hian theihtawp kan chhuah tlang thin		
8	Kan inah chuan midang ti thinrimloa mahni thinrimna an pui bawrh bawrh a theihloh		
9	Kan chhungkua ah chuan lal bik , thutlukna zawng zawng deuhthaw siam tu mi pakhat a awm		
10	Chhungkaw tangrual tak kan ni		
11	Kan mimal harsatna te kan in hrilh tawn thin		
12	Chhungkaw chimlim, thil tih dan bikte nei kan ni		

13	Inchhungah tih tur a awmin ti tu bik nih kan tum ngai lo		
14	Phur thuta che thut mai thin chhungkua kan ni		
15	Kan chhungkua chuan tih tur leh tih loh tur mumal takin kan zawm		
16	Chhungkaw member te hi kan in pui tawn nasa khawp mai		
<b>Sl. No.</b>	<b>Sawifiahna</b>	<b>Dik</b>	<b>Diklo</b>
17	Enge maw han sawisel deuh hian chhungkaw member tu emaw ber alo thinrim ve thei ziah		
18	Chhungkuaa thutlukna siam ngai a awmin kan vaiin kan sawiho a thubik kan awm ngailo		
19	Kan chhungkua chu kan tangrual lo		
20	Pawisa hmanna kan in hre pawh tlang		
21	Kan chhungkua chu mahni duh dan theuhin kan awm mai		
22	Chhungkaw inkawm ngeih tak kan ni		
23	Invengthawng deuhin kan in be thin		
24	Tih tur leh tihloh tur hi kan sawhsawn ngai lem lo		
25	Chhungkaw in ngaihsak tak kan ni		
26	A tla chawpa rorel thin chhungkua kan ni		
27	Kan chhungkuaah chuan thuruk vak a awm thei lo		

## VII : Kar li kalta chhunga I dinhmun hriatna

Slno	Zawhna	Chhanna				
1.	I nun hi nuam I ti em	Ti lo hulhual 1	Ti vak lo 2	A changing a nuam a changing a nuamlo 3	Nuam ti 4	Nuam ti luttuk 5
2.	I hriselna ah I lung awi em	Awi lo luttuk 1	Awi lo 2	Awi leh awiloh chang a awm 3	Awi e 4	Awi luttuk 5

3.	I taksa damlohna emaw natna in I duh anga nung turin a tibuai che em	5 aih	4 A changin	3 zeuh zeuh	2 aw	1 luttuk
4.	Nitina nundan pangaia nung thei turin Doctor chawh damdawi I mamawh em	5 aih	4 A changin	3 zeuh zeuh	2 aw	1 luttuk
5.	Nuam I tih ang in I nung em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
6.	I nun hian hlutna /awmzia nei in I hria em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
7.	Rilru pe deuhin rei tak I awm thei em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
8.	I nun ah hian him tawkin i inhria em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
9.	In chhungkaw boruak a hrisel em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk

10.	Nitin I tihtur ti thei turin I chak tawk em	1 aih	2A changin	3 zeuh zeuh	4 aw	5 luttuk
11.	I pianphungah I lung a awi em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
12.	I mamawh zawng leina tur pawisa i nei em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
13.	I chhehvela thil thleng I hre zung zung thei em	1 aih	2 A	3 zeuh zeuh	4 aw	5 luttuk

			changin			
<b>14.</b>	Mahni duhzawng tihna tur hunawl I nei tha em	1 aih	2 changin	3 zeuh zeuh	4 aw	5 luttuk
<b>15.</b>	I duh ang tawkin I veivak thei em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk

<b>16.</b>	I mutui thin em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
<b>17.</b>	Nitina I nun I hmandanah I lung a awi em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
<b>18.</b>	Hna thwh theih danah I lung a awi tawk em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
<b>19.</b>	Nangmah leh nangmahi I in en hian I lung a awi em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
<b>20.</b>	I mimal in laichinna neihah I lung a awi em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
<b>21.</b>	Mipat hmeichhiatna lamah I lunga awi em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
<b>22.</b>	I thianten I mamawhnaah anpui tha che em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
<b>23.</b>	Tuna in chenna hmunah khan I lungawi em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
<b>24.</b>	Damdawi lam thiam te n awm tha em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
<b>25.</b>	Vei vahna ah harsatna I nei em	1 aih	2 A changin	3 zeuh zeuh	4 aw	5 luttuk
<b>26.</b>	Rilru nuamlo, beidawng, thlaphang, huphurh nei, etc in I awm thin em	5 aih	4 A changin	3 zeuh zeuh	2 aw	1 luttuk





## **Appendices –X: Case Study Guide**

1. Does your family spend time with each other at home?
2. Does your family do things together?
3. How is household chores assigned in your family?
4. Do you find things to do together?
5. Do you carry out most activities together?
6. How does your family face issues at home?
7. Do you find it easier to discuss your problems with people outside your family?
8. Do you have any say in your family's important decision making?
9. How does your family handle your differences?
10. Does your family support each other during difficult time?
11. Do you share interests and hobbies with each other?
12. Do you feel close to each other?
13. Do you like spending your free time with each other?
14. Can you freely say what is on your mind?
15. Do you consult each other on personal decisions?
16. Do you have the freedom to express yourself?
17. Are you comfortable in expressing your opinions to your family?
18. Do you like spending your free time with each other?
19. Is there anonymity among members of your family?
20. Do you avoid each other at home?
21. Do you make compromises?
22. Do you have a good balance of leadership?
23. Does your family find it hard to know what the rules are?

24. Is it difficult to change the rules in your family?
25. Do you make decisions on your own when you are with your family?
26. Do you support each other friends?
27. Do your family members have shared close friends?
28. Do you find it easier to get closer to people outside your family?
29. 20. Do you try new ways of dealing with you problems?
30. How did you find out about your family member's addiction?
31. What is the worst thing that you have experienced about addiction?
32. What are the feelings that you associate with living with a family member with addiction?

## **Guide for Focus Group Discussion**

### ***Discussion 1: Belief (6 items)***

1. We have faith in a supreme being
2. We participate in church activities
3. We seek advice from religious advisors
4. We trust things will work out even in difficult times
5. We accept stressful events as part of life
6. We attend church services

### ***Discussion 2: Organization (10 items)***

1. Our family structure is flexible to deal with the unexpected.
2. We believe we can handle our problems
3. Our friends value us and who we are
4. The things we do for each other make us feel part of the family
5. We accept that problems occur unexpectedly
6. We are able to work through pain and come to an understanding
7. We are adaptable to demands placed on us as a family
8. We are open to new ways of doing things in our family.
9. We are understood by other family members
10. We ask neighbours for help and assistance

### ***Discussion 3: Communication (10 items)***

1. We all have input into major family decisions
2. We can question the meaning behind messages in our family
3. We can ask for clarification if we do not understand each other
4. We can be honest and direct with each other in our family
5. We can blow off steam at home without upsetting someone
6. We can deal with family differences in accepting a loss
7. We can talk about the way we communicate in our family
8. We consult with each other about decisions
9. We define problems positively to solve them.
10. We work to make sure family members are not emotionally or physically hurt

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Sl.no	Seminars/Workshops etc	Organizers	Date
1.	National online Seminar on Family, Community, Health and well-being: Patterns, Process and Outcomes of Social Work Research in India	Department of Social Work, Mizoram Univesity	23rd June-24th June 2021
2.	57 <sup>th</sup> National and 26 <sup>th</sup> International Conference of Indian Academy of Applied Psychology (IAAP)	Department of Clinical Psychology & Department of Psychology, Mizoram Univesity	27 <sup>th</sup> January-29 <sup>th</sup> January 2022

### **PAPER PRESENTED IN SEMINARS/WORKSHOPS**

<b>Sl.no</b>	<b>Title of paper</b>	<b>Name of Seminar/Workshop</b>	<b>Organizers</b>	<b>Date</b>
<b>1.</b>	<b>Coping and social support of bereaved families due to drug related deaths in Aizawl, Mizoram : A case study</b>	<b>National online Seminar on Family, Community, Health and well-being: Patterns, Process and Outcomes of Social Work Research in India</b>	<b>Department of Social Work, Mizoram Univesity</b>	<b>23rd June-24th June 2021</b>
<b>2.</b>	<b>Family functioning and family resilience among de-addiction centre inmates of Aizawl, Mizoram: A case study</b>	<b>57<sup>th</sup> National and 26<sup>th</sup> International Conference of Indian Academy of Applied Psychology (IAAP)</b>	<b>Department of Clinical Psychology &amp; Department of Psychology, Mizoram Univesity</b>	<b>27<sup>th</sup> January-29<sup>th</sup> January 2022</b>

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DEGREE : Doctor of Philosophy

DEPARTMENT : Social Work

TITLE OF THESIS : Family Functioning, Family Resilience  
And Quality of Life among Substance  
Abusers in Aizawl, Mizoram

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**ABSTRACT**  
**FAMILY FUNCTIONING, FAMILY RESILIENCE AND**  
**QUALITY OF LIFE AMONG SUBSTANCE ABUSERS IN**  
**DE-ADDICTION CENTRES OF AIZAWL, MIZORAM**

**AN ABSTRACT SUBMITTED IN PARTIAL FULFILLMENT OF**  
**THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF**  
**PHILOSOPHY**

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**DEPARTMENT OF SOCIAL WORK**  
**SCHOOL OF SOCIAL SCIENCES**

**APRIL, 2023**



**FAMILY FUNCTIONING, FAMILY RESILIENCE AND  
QUALITY OF LIFE AMONG SUBSTANCE ABUSERS IN  
DE-ADDICTION CENTRES IN AIZAWL, MIZORAM**

**BY**

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**Submitted**

**In partial fulfillment of the requirements of the degree of Doctor of  
Philosophy in Social Work of Mizoram University, Aizawl.**

## **INTRODUCTION**

According to the 2021 World Drug Report by the United Nations Office on Drugs and Crime, over 36 million individuals have drug use disorders and over 275 million people used drugs globally in the previous year (UNODC). The obsessive utilisation addictive substances disregarding negative repercussions for the user and society characterises substance abuse, a continuously relapsing condition. Studies show inclusion of family in the treatment course of the substance abuser is helpful for the family and the substance abuser. The effectiveness of treating only the person who has an active addiction disorder is constrained. Therefore, social work has always understood the importance of evaluating the individual within the context of his or her familial situation. As a result, the importance of the familial relationship between the individual and their environment is emphasised throughout social work practice (O'Farrell & Fals-Stewart, 2000).

Family has an important effect on a person's psychological behaviour. Family functioning is a concept that explains how family members can advance and foster their physical, mental, and sustainable changes in a beneficial and positive manner by obtaining the spiritual and material conditions from their family. Individual drug usage is strongly associated with family functioning. Researches have concluded that individuals who connect well with members of the family, especially their parents, are less inclined to participate in behavior problems. A major factor in male substance abuse is family functioning. Also, it has been revealed that a person's illegal substance abuse behaviour is tied to the functioning of their family. Adolescents with high family functioning are less likely to take drugs than their counterparts with poor family functioning (Hosseini Nasab et al., 2004).

Understanding the nature of risk and resilience in families is recognized as the key to preventing and treating drug and alcohol abuse in substance-affected families. This need is a crucial concern as substance abuse is one of the leading issues faced by families and society in the United States. Recent estimates indicate that 8.3 million children live in substance-affected families where parents have alcohol or other drug problems (Hawkins, Catalano, & Miller, 2012).

Quality of life (QoL) is a significant marker and outcome in the management and treatment of chronic diseases, including substance use disorders (SUD). More and more often, subjective patient assessments of results apart from morbidity and mortality and quality of life are used to evaluate the efficacy of chronic disease treatments (Smith, 2003).

SUD sufferers often rate their quality of life as bad as those with other severe psychiatric diseases and much worse than the general public (Tiffany et al., 2012). Low quality of life may also indicate a patient's readiness for treatment; qualitative approach studies have revealed that patients are more explicitly interested in improving their quality of life than reducing their substance use (Laudet, 2009). It's interesting to note that SUD-specific factors, such as drug kinds utilised, frequency of use, and duration of problematic use, have not consistently been associated with low quality of life (De Mayer et al., 2010). Yet QoL also contributes to SUD recovery: Laudet et al. discovered that better QoL after therapy discharge predicted abstinence than conventional SUD traits (Laudet, 2009). In addition to assessing quality of life for its own sake as a subjective indicator of functioning (Tracy et al., 2012), examining and resolving the dissatisfaction with different life domains that reduced quality of life may enhance abstinence outcomes and enable patients to gain access to a wider array of health advantages after treatment (Laudet, 2011).

## **REVIEW OF LITERATURE**

### **Studies on Family Functioning:**

Family Functioning is the patterns of relating or family processes over time (Dobkin et al., 2002). A healthy family offers a setting that promotes the successful growth and safety of its members. This result represents a family environment that is safe, harmonious, and mutually supportive. It is one that is defined by appropriate roles, open dialogue, regular expression of positive effects, and one that is founded on a common set of customs and beliefs.

The National Household Survey on Drug Abuse (NHSDA), conducted in 2000 and 2001, found that 20.5% of those 12 and over reported binge drinking (defined as

more than 5 drinks on at least one occasion during the past 30 days). An additional 5.7 % (or 12.9 million people) reported heavy drinking (defined as 5 or more drinks on the same occasion more than 5 days in the past 30 days). An estimated 7.1% of the population or 15.9 million people over the age of 12 reported the use of an illicit drug within a month of the interview (SAMHSA, 2001)

Studies have found that there are other important factors linking substance abuse directly to the family. For example, children who grow up with an alcoholic parent are at increased risk of abusing Family history is further implicated in substance-abusing parents are more likely to have grown up in chaotic and emotionally problematic family environments: families characterized by psychological maltreatment due to parental neglect, physical or sexual abuse, economic distress, and other family depleting conditions. Moreover, parents from substance-abusing homes are more likely to report the parenting styles of their parents as punitive and authoritarian (Grant, 2000).

### **Study on Family Resilience**

The process of successfully navigating, adhering to, or managing substantial stress factors or trauma is referred to as resilience. This ability to adapt and "bounce back" in the face of hardship is made possible by the assets and resources that an individual has access to within their everyday lives and surroundings (Windle, 2011). This allows the family to return to previous levels of functioning following a challenge or crisis.

In order to effectively treat and prevent alcohol and other drug addiction, it is crucial to take into account the notions of "risk and resiliency" (McCubbin, McCubbin, Thompson & Han, 1999). Risk is the collection of elements that affects the likelihood that a person would use and become dependent on drugs. The ability to prevent or recover from the negative effects of alcohol or drug usage is referred to as resilience. The assessment of risk and resiliency in relation to families is significantly more difficult but crucial to avoid or reduce the harmful impacts of substance misuse on both the person and the family. Family risk is greater than the sum of the risks for

each family member (and, conversely, resilience or protective factors). Instead, it focuses on the contributions that family members make to the dynamics of the family, its functions, and the choice of the family as an entity (McCubbin, McCubbin, Thompson & Han, 1999).

### **Studies on Quality of Life**

Quality of life primarily refers to how a person evaluates the general "goodness" of various facets of their existence. These assessments cover emotional responses to events in life, disposition, sense of fulfilment and contentment in life, and satisfaction with one's career and interpersonal associations (Cummins, 2005). A simplistic definition of quality of life is satisfaction within multiple life areas (The WHOQOL Group, 1995). Veenhoven (2010).

Drug use can have an impact on a variety of facets of life, including social and other connections, employment potential, and physical and psychological functioning (Laudet, 2011; De Maeyer et al., 2013; 2010; Fakhoury & Priebe, 2002; Marini et al., 2013; Zubaran & Foresti, 2009). This begs the question of how much drug users actually gain the advantages they desire.

While improving QOL through abstinence is the ultimate goal of treatment (Laudet, 2011), studies have shown that improved QOL may go transcend abstinence (Tracy et al., 2012; de Maeyer et al., 2010; Garner et al., 2014). According to Tiffany et al. (2012) and Laudet (2011), changes in QOL assessments appear to include perceived changes to subjective domains. These domains cover a variety of topics such as social interactions (Tracy et al., 2012; Marini et al., 2013; De Maeyer et al., 2013), extracurricular activities (Best et al., 2013), job (Marini et al., 2013), and housing circumstances.

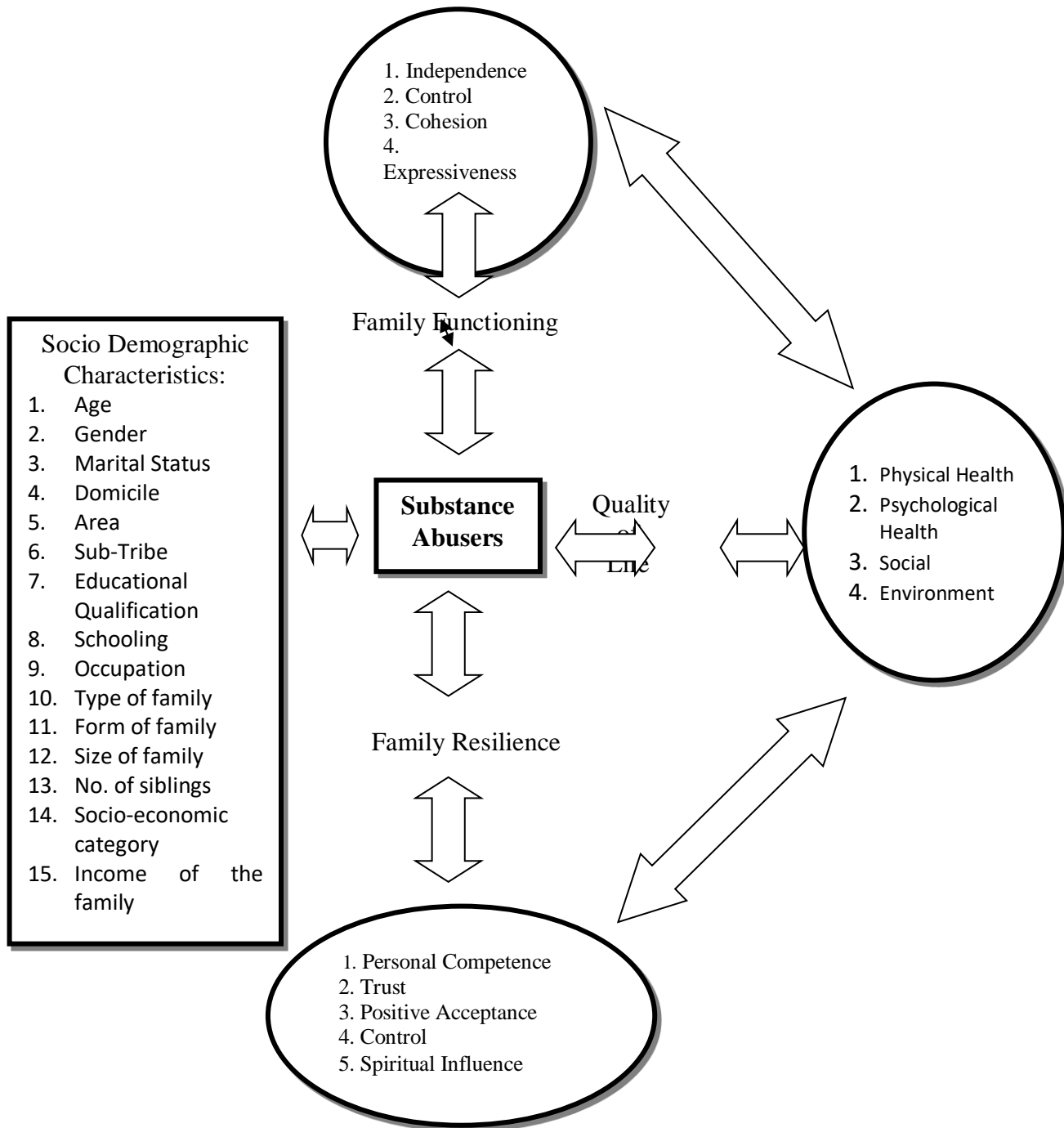
### **CONCEPTUAL FRAMEWORK OF THE STUDY**

The conceptual framework of a study is a model built with various variables which are examined through various works of literature. After understanding the concepts, the researcher can construct the conceptual framework. As the research

deals with family functioning, family resilience and quality of life among substance abusers the researcher has presented the concept in **Figure 1**.

The conceptual framework portrayed in **Figure 1** is adapted from variables based on the understanding of the researcher. In this model, the socio-demographic characteristics of the respondents, family functioning, family resilience and quality of life are displayed. As the level of family functioning rises substance abusers will have better quality of life. When the level of family resilience is high substance abusers will have better quality of life. This reveals that QOL, family functioning and family resilience are all linked and interrelated.

**Figure 1: CONCEPTUAL FRAMEWORK**



Source : Constructed by the researcher.

## **STATEMENT OF THE PROBLEM**

Drug abuse is a global phenomenon. The use of substances, in some form or another, is universal. In 2011, between 167 and 315 million people aged between 15 - 64 were estimated to have used an illicit substance in the preceding year. This corresponds to between 3.6 and 6.9 per cent of the population. Polydrug use, especially a combination of drugs and illicit substances, continues to be a concern.

Alcohol and drug abuse has emerged as a serious concern in India. The geographical location of the country makes it highly vulnerable to the problem of drug abuse. Currently, India is not merely a country for the transit of such drugs from the 'Golden Triangle' or 'Golden crescent'; it has also become a country of consumption (MSJ&E, 2013). As per the National Survey of Extent, Pattern and Trend of Drug abuse in India, sponsored by the Ministry of Social Justice and Empowerment and by the United Nations Office on Drugs and Crime, Regional Office South Asia (UNODC- ROSA) in 2000-2001 and published in 2004, it was estimated that about 73.2 million persons were users of alcohol and drugs. Of these 8.7, 2.0 and 62.5 million were users of Cannabis, opium and Alcohol respectively. About 26%, 22% and 17% of the users of the three types respectively were found to be dependent on/addicted to them (R.Ray, 2004).

Northeastern states of India, due to their geographic positioning among other several factors were vulnerable to high patterns of substance abuse. Of the eight North-eastern states, namely Assam, Meghalaya, Sikkim, Tripura, Arunachal Pradesh, Manipur, Mizoram and Nagaland, the last four share a common international border with Myanmar, the world's second-largest illicit opium-producing country. Following the introduction of heroin in the early 1970s, within ten years, many local young males, and to a lesser extent young females- in their mid-teens started injecting heroin (Panda, S).

It is difficult to pinpoint the exact time when drug abuse entered Mizoram but it has been observed that the children of the rich who could afford to buy were the



first victims (Ralte, J.M., 1994., Lalkima, C. 1997., Lianthanga, K. 1998). In all probability, the Mizo youth who were exposed to various colleges in the metropolis of India during the 1960s and 70s experienced various drugs. It was in the later part of the 1980s when 'drug abuse' really established its foothold and drugs related health problems were recorded in Mizoram. According to the survey conducted by the Central KTP (Youth Fellowship, Presbyterian Church ) in 1998, there were 15,188 drug users in Mizoram of whom 14, 347 (94.46%) were male and 841 (5.33%) were female(Hmingthanmawii,2000). In 2013, a total of 10,750 injecting drug users were validated by the Mizoram AIDS Control Society.

Treatment centre population mapping conducted by MSD&RB in September 2012 reveals that there are 242 inmates in 10 centres funded by the Government and 1,789 inmates in 28 NGOs. Altogether there are 2,031 inmates in drug treatment centres in Mizoram at the time of the mapping (MSD&RB, 2013). Although the family has been viewed as an important factor in the rehabilitation process (Sander et al, 2002), there is limited research on the relationship between the family and the quality of life of substance abusers

## **OBJECTIVES**

The objectives of the study are as follows:

1. To understand the patterns of substance abuse.
2. To assess the family functioning of substance abusers.
3. To assess the family resilience of substance abusers.
4. To examine the quality of life of substance abusers.
5. To assess the relationship between family functioning, family resilience and quality of life of substance abusers.

## **HYPOTHESIS**

The following hypotheses are based on the constructs of quality of life, family functioning and family resilience:

1. Greater family resilience better the quality of life of substance abusers.
2. Better family functioning better the quality of life of substance abusers.

## **METHODOLOGY**

This study covered aspects related to family functioning, family resilience and quality of life among substance users in De-addiction Centres in Aizawl. The study is exploratory in design and cross-sectional in nature. The number of substance abusers is not recorded and often there is no recording of substance abusers because there is unreliable data. The issue of substance abuse and in particular its relationship with family is very sensitive; hence the methodology used in this study further lent itself well to qualitative approaches, quantitative approaches are also adopted when appropriate. For the qualitative data, Case Study and Focus Group Discussion were conducted. The respondent's family members were taken as a unit of the study. Further the FGD covering the beliefs, organizational patterns and communication processes were covered and the challenges faced by the respondents were discussed. Since this is a study based on individual experiences, participants were selected using systematic sampling.

Multi-stage Sampling was adopted. In the first stage, Aizawl was purposively selected because it records the highest number of De-Addiction Centers in Mizoram (MSD & RB, 2015). In the next stage, three de-addiction centres with the highest number of bed capacities were selected. In the third stage of sampling, a final sample was selected using proportionate sampling to keep gender and the centres represented. The unit of the study is individual.

Primary data was collected through both quantitative and qualitative methods. The quantitative data was collected from substance abusers using an Interview Schedule to collect information related to Socio-demographic characteristics, Family Environment

Scale is used to assess family functioning, family resilience and the Quality of Life (WHOQOL-BREF, 1997) standardised scale was used. The qualitative data was collected through in-depth interviews and focus group discussions, reflected by five case studies which were conducted among the family of substance abusers. The secondary data was collected through available journal articles, books, magazines, annual reports and open access articles with the help of web sources.

The quantitative primary data collected through the Interview Schedule was edited, coded and processed with the help of Microsoft Excel and analyzed with the SPSS package. The analysed data was presented in the form of two-way tables and figures. The researcher used both descriptive statistics and non-parametric tests like Spearman's Correlation, KruskalWalley test and Mann U Whitney test.

## **CHAPTER SCHEME**

The present study is organised into nine chapters.

Chapter I	Introduction
Chapter II	Review of Literature
Chapter III	Methodology
Chapter IV	Socio Demographic Profile of the respondents
Chapter V	Patterns of Substance Use among Substance Abusers
Chapter VI	Family Functioning of Substance Abusers
Chapter VII	Family Resilience of Substance Abusers
Chapter VIII	Quality of Life of Substance Abusers
Chapter IX	Conclusion and Suggestions

## **RESULTS AND DISCUSSIONS**

### **Socio-Demographic Profile of the Respondents**

The socio-demographic profile of the respondents includes age, marital status, educational qualification, sub-tribe, economic characteristics of the respondents, familial characteristics of the respondents, descriptive statistics of respondents and parental profile of the respondents. The majority (73.25%) of the respondents belong to the age group between 14- 40 years with which the majority (83.88%) were female

respondents. The mean age of male respondents was higher than that of female respondents by three years. A majority (38.54%) of the respondent's level of education was high-school.

Almost half (48.06%) of the respondents belong to the Lusei sub-tribe, this is because Lusei is the major sub-tribe in Mizo society. The area of the respondents shows that the majority of the respondents (84.88%) were from urban areas Majority of the respondents (81.40%) were from core areas.

Half of them belong to the low-income category (50.39%) and only a few (7.36%) belong to the high income. This indicates that substance abusers in Mizoram families with a high level of income are not as frequent in de-addiction centres as compared to those with low income.

Majority of the families (93.02%) belong to nuclear families and more than half (67.05%) of the respondents belong to medium size family. This is because nuclear family and medium size family is more common in the Mizo society

This shows that a large family is not common among the Mizo family. There is a huge gap between the amount spent on substances per day as the minimum stands at 20 rupees while the maximum stands at 1000 this reflects that the choice of substances has a huge influence on money spent and the daily dose is a contributing factor.

Parents' education, parents occupation and parents income show that a few of the parents are illiterate, most of the parents are privately employed and a majority are middle earners

### **Pattern of Substance use among Substance Abusers**

A pattern of substance use among substance abusers includes the descriptive statistics of patterns of drug use by gender, respondents' drug use pattern at first use by gender, respondents' drug use pattern at second use by gender, respondents' drug use pattern at third use by gender, respondents drug use pattern at fourth use by gender

The respondents' first use mean age is 11.5, second use the respondents' mean age is 14.49, in the third 18.79. In the fourth use, the respondents' mean age is 20.74. All the respondents take their first substance orally; a majority of the respondents used their first substance for about 6-12 months. The type of second abuse of substances is alcohol, cannabis, and cough syrup, The age group of second use shows that half (50%) of the male respondents started their second substance while were children while more than half (60.48%) of the female respondents started their second substance while they were children.

The age group of third use shows that more than half (52.24%) of the male respondents started their third substance in their young adulthood while half (50.81%) of the female respondents started their third substance in their young adulthood. The duration of use shows that the majority (88.81%) of the male respondents and the majority (81.45%) of the female respondents use their third substance of choice for more than 24 months respectively.

More than a third of the total respondents (38.37%) do not use fourth substances. The type of fourth substance choices is heroin, cough syrup and spasmoproxyvon. There is not much difference among the male and female respondents in their age group as young adults are the highest users in both genders.

### **Family Functioning of Substance Abusers**

The qualitative discussion on family functioning of substance reveals the family found it challenging to accept the need to satisfy this need at all costs and focus solely on obtaining and consuming drugs. The family feels ashamed and embarrassed as a result. Despite their public declarations, they avoided engaging with their extended family in any public acknowledgement of his drug use. The interviewees acknowledged that they initially experienced rage, trouble falling asleep, nausea, and an inability to carry out daily chores. They also discussed how addiction affects a family's ability to make money, as well as its physical and mental health.

The fact that humour has been employed as a coping method was mentioned. A family member will make an effort to be humorous in the hopes that his or her

humour will be noticed and will continue to play this function in order to maintain peace and harmony in the home.

The descriptive statistic section of this chapter shows that in all the domains of family functioning- Cohesion, expressiveness, independence, and control females have better family functioning than males. Among the respondents, almost half of the female respondents (44.35%) have a high level of family functioning, while more than a third of the male respondents (35.07%) have a high level of family functioning. Majority of the respondents (52.08%) that live in the periphery have high family functioning while less than a fifth (18.75%) of the respondents living in the same area have low family functioning. Majority of the respondents that live in rural have high (41.03%) and moderate(41.03%) levels of family functioning while less than a fifth (17.95%) of the respondents living in rural domiciles have low family functioning levels.

The respondents living in rural domiciles and periphery areas have better family functioning. The majority of adults have low family functioning more than a third of the adult respondents have moderate family functioning and a third has high family functioning. The table shows that among the adults, age group between 24- 40 years of age, the majority of the respondents have low family functioning and half of the BPL respondents have low family functioning.

As per the chi-square test for association among the type of substance, age, duration and money spent at first use and level of family functioning, it is found that there is a relationship between type of first substance use and level of family functioning, age at first use and level of family functioning duration of first use and level of family functioning, there is a relationship between daily money spent and level of family functioning.

As per the Chi-square test for association among the type of substance, age, duration and money spent at third use and level of family functioning ,it is found that there is a relationship between type of third substance use and level of family functioning, age group third substance use and the level of family functioning, duration of third substance use and the level of family functioning, mode of use of

third substance use and level of family functioning, money spent on third substance use and level of family functioning

The Spearman's inter-correlation matrix of family functioning reveals that there is a strong correlation between cohesion and expressiveness, control and cohesion, control and expressiveness, and control and independence. At the same time in the domain of independence, there is a significant relationship between independence and cohesion, independence and expressiveness. The overall family functioning shows that there is a strong positive correlation across the domains.

Among the overall family functioning domains, the majority mean rank (150.30) is found in periphery respondents. However, there was no significant difference between the areas. Hence, the table shows that the four domains in ascending order among the core respondents are independence, expressiveness, cohesion and control. And for the periphery, the four domains in ascending order are control, cohesion, expressiveness and independence.

The Mann-Whitney U test shows the significant difference between the mean rank of gender across family functioning and the mean rank of area across gender. that among the overall family functioning domains, the majority mean rank (150.30) is found in periphery respondents. However, there was no significant difference between the areas. The four domains in ascending order among the core respondents are independence, expressiveness, cohesion and control. And for the periphery, the four domains in ascending order are control, cohesion, expressiveness and independence.

In the mean rank of area across family functioning in the cohesion domain in which the majority (149.14) is from the periphery than the core (125.01). Among the overall family functioning domains, the majority mean rank (150.30) is found in periphery respondents. However, there was no significant difference between the areas. The four domains in ascending order among the core respondents are independence, expressiveness, cohesion and control. And for the periphery, the four domains in ascending order are control, cohesion, expressiveness and independence.

## **Family Resilience of Substance Abusers**

In the Focus Group Discussion the families of substance abusers have discussed the difficulties they experience as a result of weak bonds and a lack of support during difficult times. They frequently struggle to come together and get through these trying moments as a group. Family members and drug users frequently feel a sense of mistrust for one another. This makes their family's struggles much more difficult and makes it more difficult for them to work together to find a workable solution. It was explained how these stresses on interpersonal relationships, brought on by a lack of honest interaction and an unsupportive atmosphere, make families more susceptible to crises and lead to greater drifts in their interpersonal relationships.

Families suffering with substance misuse made it clear that when the symptoms of addiction cause their surroundings to shift, they find it challenging to adapt. They struggle to preserve stability and continuity in the way the family functions and find it hard to deal with the unexpected, unpredictable changes. Their attention is mostly on immediate requirements, which makes it practically impossible for them to have any long-term effective planning because their resistance to change frequently leads to stress and inadequate crisis responses. They feel uneasy making adjustments because they believe the substance user may react negatively out of retaliation or revenge.

They have also spoken about how they often struggle with emotional expression and find it difficult to convey their feelings, even to one another. They have little verbal and nonverbal communication, and they have trouble opening up. When discussing their feelings, they frequently show unease and discomfort, and their facial expressions are frequently ambiguous. They are unable to verbally or nonverbally communicate their emotions. Their body language is cold and reserved, and they are very cautious about displaying any form of directness and openness.



Family resilience of substance abusers includes a level of resilience by gender, level of resilience by domicile and area, level of resilience by age group, annual family income and level of resilience by respondents' chi-square test for association between family functioning and resilience, Kruskal Wallis test for significant difference among the mean rank of resilience level concerning factors of family functioning.

The majority of the respondents have an average level of family resiliency and more than half of the respondents with an average level of resilience have an unstable family. The majority of the respondents with an average level of family resiliency lives in urban domicile and core area. Majority of the respondents have an average level of family resiliency in which more than half belongs to the adult age group. While a few of the middle-aged have high levels of family resilience. Majority of the respondents with a high level of family resilience belong to BPL families and a majority of the respondents with high family resilience belong to the respondents with low annual family income. As per the Chi-square test 10.683 and a P-value of 0.30 which is significant at a 0.05 level. There is a relationship between family functioning and family resilience.

The Kruskal Wallis test for significant differences among the mean rank of resilience level with respect to factors of family functioning shows that the mean rank for the high resilience level is the highest in all the domains, Since the P-value is less than 0.01, the null hypothesis is rejected at the 1% level about the significant difference between mean ranks of resilience level across the domains of family functioning. There is a significant difference between mean ranks of resilience level across the domains of family functioning such as cohesion, control expressiveness. However there is no significant relationship between the independence domain and family functioning.

### **Quality of Life of Substance Abusers**

The quality of life of substance abusers includes respondents' mean score by gender and form of family, respondents' mean score by domicile and area, and respondents' level of quality of life by gender, domicile and area.

The overall QOL mean score shows that stable families have higher overall QOL than unstable families. Respondents living in urban domiciles and core areas have a better quality of life. The above table shows that the majority of the respondents across gender, domicile and area have a moderate level of quality of life. Among the respondents, almost three-fourths (72.48%) are in the Average level of family resilience with which the majority (74.58%) are in the moderate level of QOL.

The Chi-square test is 12.878<sup>a</sup> and has a P-value of .045 which is significant at a 0.01 level and there is a relationship between QOL and age group. there is a relationship between family functioning and QOL.

The Spearman's inter-correlation matrix of quality of life reveals that there is a moderate correlation between psychological and physical domains, a low positive correlation between social and physical and a moderate positive correlation between social and psychological. At the same time in the domain of environment, a low correlation between environmental and physical, environmental and psychological, and environmental and social. The overall quality of life shows that there is a positive correlation across the domains.

The Mann-Whitney U test significant difference between the mean rank of gender, domicile and area across the quality of life shows that among the overall quality of life domains, the majority mean rank (131.52) is found in male respondents. However, there was no significant difference between the genders. Hence, the table shows that the four domains in ascending order among the male respondents are physical, social, psychological and environmental. And for females, the four domains in ascending order are environmental, psychological, social and physical.

Among the overall quality of life domains, the majority mean rank (130.74) is found in urban respondents. However, there was no significant difference between the domiciles. Hence, the table shows that the four domains in ascending order among the urban respondents are environmental, physical, social and psychological. And for rural, the four domains in ascending order are psychological, social, physical and environmental

Among the overall quality of life domains, the majority mean rank (136.29) is found in periphery respondents. However, there was no significant difference between the areas. Hence, the table shows that the four domains in ascending order among the core respondents are environmental, psychological, physical and social and environmental. And for the periphery, the four domains in ascending order are, social, physical, psychological and environmental.

The Kruskal Wallis test for significant differences among the mean rank of age groups across Family functioning and Quality of life shows that while comparing the age group in the mean rank scores, it was found that the mean ranks of children are social (148.06), physical (135.75), psychological (133.31) and environment (129.28). Similarly, the mean ranks for youth are environment (128.28), psychological (125.80), physical (124.48) and social (120.54). Among adults, the mean rank is highest (137.14) in the psychological domain, social (133.88), environment (132.04), and physical (125.38). Among the overall coping domains, the majority mean rank (148.38) is found among the Children age group. Among the overall QOL domains, the majority mean rank (148.38) is found among the children age group.

Based on the mean ranks, respondents belonging to the middle age group have better physical health, and the children age group have better social relationships. The respondents belonging to the adult age group have better psychological health and a better environment rather than the children, youth and middle age which indicates that the adult age group are more concerned regarding a better environment and the children age group has better overall QOL. Respondents belonging to the young age group have a better quality of life than the middle and old age groups.

## **SUGGESTIONS**

1. Strategies to cope with substance abuse must be multifaceted and viewed as lifelong processes to maximize the wellness of individuals and family systems.
2. Family should provide freedom, space and stability to enable members to grow and develop in various domains.

3. A comprehensive understanding of the role of the family in addictive disorders is needed to help clinicians and families deal with the problem in a better way.
4. Acknowledging and understanding the difficulties faced by children of drug-abusing parents to identify protective buffers will be helpful.
5. In educational settings teachers can foster resiliency by modelling appropriate behaviours, using a proactive curriculum, and promoting interactions, both individually and with social service delivery systems that are in the best interests of children.
6. Incorporate family activities that includes all families, and begin to build substance abuse prevention into the activities
7. In service training is needed to help identify children and parents in high risk situations, the needs of these families, and intervention strategies based on resiliency models.
8. It is essential to expand and modify current methods of assessing incidence and prevalence and impact of substance abuse in terms of the individual substance abuser in order to capture the family as a whole.
9. Understanding family involvement in recovery efforts along a continuum based on the substance abuser's level of motivation will take developmental factors into account.
10. It is critical to consider the impact a family member may have as a function of multiple roles and their impact on different family function characteristics and for how substance abuse affects the roles and responsibilities associated with each of these roles.

## **SUGGESTIONS FOR SOCIAL WORKERS**

The purpose of the study is to identify the social work intervention. From the findings, the researcher can link that there is scope for social work intervention in the context of the present study; social workers can intervene in the following manner:

1. A social worker is a member of the multidisciplinary team who can serve as a support to substance abusers and their families.

2. The social worker would facilitate the substance abuser and listen to their feelings, thoughts, and reactions to their substance-abusing life and talk to them about their worries and concerns.
3. Psychiatric social workers and Medical social workers could offer counselling services in the de-addiction centre, drop-in centres and community.
4. The social worker could teach anger management, and relaxation techniques to help to reduce stress or anxiety or other fears associated with substance abuse.
5. The social worker could also provide emotional support, to strengthen the family functioning, family resilience and quality of life of substance abusers.
6. The social worker could advocate on the importance of including families in the treatment of substance abusers.
7. The social worker could mediate between substance abusers and their family in order to help them understand each other better
8. The social worker could do more researches on family functioning and substance abuse, family resilience and substance abuse, quality of life and substance abuse.
9. To increase the understanding and the development of more effective interventions, more research needs to focus on the impact on substance abuse in families over time, and not just during isolated contacts with treatment providers as family is dynamic and ever changing with time.

## **IMPLICATION FOR SOCIAL WORK PRACTICE**

Social work is a new profession more than eight decades old in India. It has its philosophies and principles, knowledge and values, methods, skills and techniques to be practised or intervened by the individuals, groups and communities, those who have encountered challenges in society. Through these social work processes, the clients or the people realize the problems encountered and work out the modalities in such a way that the potential and resources are utilized to remove the cause deals with the symptoms and reduce the magnitude of the problem. In this area there is enough scope to practice the methods of social work such as the primary methods of working

with individuals, working with groups, working with communities and the secondary methods namely, social action, social welfare administration and social research.

The primary methods of social work have wider implications for social work to provide counselling one-one basis, group work can be conducted for the different age groups in the hospital setting, especially for the substance abusers and their families at the micro-level of interventions.

The community organisation method also facilitates the social workers to do meso/mezzo level of intervention in the communities with the help of civil society organisations like Women Association, Youth Associations and elderly associations which are available in the community by which the social workers play a vital role in the prevention, and awareness generation about substance abuse.

In the secondary social work methods, there is high scope for social work research since there is a dearth of empirical studies on the family of substance abusers and their quality of life.

The present study provides a comprehensive understanding knowledge that familiarises the social worker with family functioning, family resilience and QOL of substance abusers. Subsequently, the social work fraternity must delve into the relationship between family and substance abuse. Taking into consideration the magnitude of the challenges faced by substance abusers and their families, the Government must bring out a separate programme and policy for addressing the issue, so the present study suggests National Programme for Prevention and control of Substance abuse could be operated in each state with help of Ministry of Social Welfare.

## **SCOPE FOR FUTURE RESEARCH**

From the deliberation of the present study, the researcher can explore the scope of future research. Therefore, the scope for future research has been suggested in the following areas

1. There is a wide scope in areas such as community studies, a comparative study of rural and urban where rural communities and urban communities can be selected for the study.
2. Social work Research could be focused on an empirical understanding of the psychosocial experiences for dealing with the challenges of substance abusers and their families
3. The families of substance abusers are very important to have an in-depth understanding of the challenges faced by substance abusers. There is a scope for future research among the families of Substance abusers to explore the impact on the family as well as the issues and challenges faced by the substance abusers.
4. In future research, there is scope for an in-depth study on the lifestyle of substance abusers